

DOCUMENT RESUME

ED 127 743

EC 090 971

AUTHOR Byrne, Jane M., Comp.
TITLE Early Intervention Program Resource Guide: Selected Readings from Programs for Young Disabled Children in Pennsylvania.
INSTITUTION Pennsylvania State Dept. of Public Welfare, Harrisburg. Office of Mental Retardation.
SPONS AGENCY Bureau of Elementary and Secondary Education (DHEW/OE), Washington, D.C.
PUB DATE [76]
GRANT 48-76005-41-440
NOTE 107p.
EDRS PRICE MF-\$0.83 HC-\$6.01 Plus Postage.
DESCRIPTORS Community Attitudes; Demonstration Projects; Early Childhood; Educational Diagnosis; Exceptional Child Education; Family Counseling; *Handicapped Children; *Identification; Individualized Instruction; Infancy; *Intervention; Medical Treatment; *Program Descriptions; Program Development; Residential Programs; *Resource Guides
IDENTIFIERS *Developmental Disabilities; *Pennsylvania

ABSTRACT

Intended as a guide for professionals and local administrators in initiating and developing early intervention programs for handicapped children, the volume provides descriptions of 10 models and techniques presently utilized in Pennsylvania. Included are reports with the following titles and authors: "A System of Open Learning" (P. Malone), "A Description of Intervention Strategies for Handicapped Infants and Toddlers" (M. Mostertz, et al), "New Beginnings: A Center-Based Training Program for Families of Developmentally Delayed Infants and Toddlers" (C. Lapidakis), "Early Intervention Project for Behaviorally Disordered Preschoolers" (J. Reisinger and F. Gray), "A Multidimensional Early Intervention Program Model" (K. O'Connor), "An Integrated Early Intervention Project" (A. Vogeding), "Educational Programming Consideration: The Medically Involved Child in a Community Residential Setting" (H. Lynch and D. Misner), "A Community System for Serving Young Children and Their Families" (K. Sims), "Cooperation with the Medical Community: The Key to Success of Early Intervention Programs" (M. Perrin and M. Sgro), and "An Innovative Approach for Community Education About Early Intervention" (L. Fiorentino, et al). A bibliography of 118 current readings in early intervention is provided, and addresses of the contributors are included. (IM)

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EARLY INTERVENTION PROGRAM RESOURCE GUIDE

Selected Readings from Programs for Young Disabled Children in Pennsylvania

Compiled and Edited by

Jane M. Byrne

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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Funds for printing this Guide were provided through a
grant #48-76005-41-440 under Title I, ESEA, P. L. 89-313 as amended.

EC090971

Introduction

The history of Early Intervention Programs in Pennsylvania closely parallels that of similar programs throughout the Nation. Earliest efforts in our State to provide community-based educational services to disabled preschool children can be attributed to Advocacy Groups like the Retarded Citizens and United Cerebral Palsy Associations, Easter Seal Societies, and Crippled Children's Organizations. These pioneer programs were initiated -- and survived -- with a minimum of financial support from local fund-raising campaigns, contributions, and, in some rare cases, private foundation grants. Most often, staff was made up of parents, volunteers, and dedicated members of the local professional community who donated time whenever possible.

While these Advocacy Groups continue to be among major providers of Early Intervention Programs, many significant changes have occurred. The past ten years have seen tremendous growth in Pennsylvania's educational services to disabled children, including very young children. This growth has resulted from several factors including (1) Pennsylvania's consent agreement establishing the Right to Education for all school aged mentally retarded children, (2) increased State and Federal financial support, and (3) development and refinement of program resource materials.

The Pennsylvania Department of Public Welfare administers a wide variety of funds which support educational programs for disabled preschool children. In 1975, over 4,500 such children, birth through 5 years of age, participated in programs in over 100 community agencies throughout the State. Expenditure of Local, State, and Federal funds administered by the Department for this purpose exceeded \$13 million dollars.

Concomitant with increased financial support for Early Intervention Programs has been development of staff expertise, and new approaches to service delivery. Projects like the United Cerebral Palsy's National Infant Collaborative Project and other USOE-BEH sponsored model early childhood education programs have had substantial impact in our State. More directly, years of experience in working with young disabled children and their families have created sound philo-

sophical and operational premises among Service Providers, fostering program development.

This Resource Guide was developed to describe some of the models and techniques being utilized in Pennsylvania to provide Early Intervention programs. Articles were prepared by staff persons who work directly with young disabled children each day in community agencies. The Guide is intended to assist professionals and local administrators in initiating and developing such programs.

In selecting articles to be included, an attempt was made to demonstrate our belief in the importance of designing a number of flexible program models which reflect the various life styles of families and the developmental needs of children. A sample is included to illustrate the four most prevalent program models in operation in Pennsylvania – i.e., totally home-based, specialized center/home based combination, full time specialized center-based, and integrated center-based models. Other articles were selected to demonstrate special approaches and techniques in community education and parent training.

The programs described in this Guide represent only a limited sampling of the many fine Early Intervention Programs operating in our State. With the rapidly developing "state of the art," changes occur daily. Many of the ideas contained in the Guide, and featured as innovative, may appear, a year from now as basic – perhaps even primitive. However, it is hoped that the experiences and information shared herein will further the development of quality programs for young disabled children.

The article below describes the Early Assessment and Treatment Program Model at the Handicapped Children's Unit of St. Christopher's Hospital for Children in Philadelphia, with particular emphasis on the System of Open Learning Techniques.

A System of Open Learning

by

Paula Malone, Ph.D.

Children, all children, learn best in an environment which is responsive and dynamic. In this type of environment, living, open, dynamic, but most of all systematically responsive, all children can develop optimally and progress. The System of Open Learning (SOL) to be described in this paper creates an opportunity for learning through the creation of an "autotelic responsive environment" (Moore and Anderson, 1968). By definition this environment permits the learner to explore a situation freely; it informs the learner immediately about the consequences of his actions; it is self pacing, i.e., events happen within the environment at a rate determined by the learner; it permits the learner to make full use of his capacity for discovering relations of various kinds; and its structure is such that the learner is likely to make a series of interconnected discoveries about the physical, cultural and social world (Moore, 1964, quoted in Meier, 1973). The System of Open Learning provides a format and a vehicle for the creation of an autotelic responsive environment. The goals of SOL are to develop a positive self image and a socio-cultural participation, to increase sensory and perceptual acuity, to improve problem solving and concept formation abilities, and to develop motor and language function. These goals are not different from any other curriculum but in the SOL, the adult is not a teacher to the child but is a learning facilitator. This difference is not simply one of semantics but represents a

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philosophical/theoretical difference between SOL and other techniques of programming for children. "Prescriptive teaching" is not a part of this system, but the creation of precisely relevant learning environments, and the facilitating of exactly appropriate learning episodes is.

The System of Open Learning is presented in three volumes. Volumes I and III by John Meier state the rationale and training procedures for the System. Volume II, by Meier and Malone (1976) is a revision of an earlier volume which presented only preschool materials and which now has over 150 learning episodes in loose leaf form for infants and young children. These learning episodes in Volume II are presented in an information processing format and represent the learner as receiver, operator, and expresser responding to and requiring responses of his environment. Learning episodes are, therefore, categorized according to Sensory/Receptive (listening, looking, touching, and sensory integration), Cognitive (content, process, and self image), and Expressive (fine motor/gross motor, language, self help and social). Of course, the categories of learning episodes are not mutually exclusive, i.e., a learning episode primarily involving cognitive content can also involve visual, auditory and communication capabilities. The two learning episodes which follow illustrate the format.

Unit I 10 Gross Motor

Episode G - Going Over Obstacles To Get A Toy

Purpose

Learner learns to plan his movements to successfully overcome obstacles in his environment. Learner learns to persist in order to get what he wants.

Entry Behavior

Learner can creep on all fours with ease.

Material

Homemade obstacles such as pillows, chairs, on their sides, boxes with the ends cut out, etc.

Procedure

Put a favorite toy or something else the learner likes on the floor so that the learner can see it. Put one or two obstacles in his way to start and then encourage him to move toward the toy. These obstacles should be things that the learner can go under, around or over with some ease such as pillows, chairs on their sides, boxes with the ends out for crawling through, etc. You will need to encourage the learner toward the toy to make it fun instead of being frustrating. Once the learner enjoys the challenge, you can make it more difficult by using many obstacles or things that are difficult for him to get around. Do not let him become discouraged or he will simply crawl off to another, less troublesome game.

Terminal Behavior

Learner crawls or walks easily through, around, under or over whatever obstacles are placed in his way in order to get the reward.

Unit T 2 Looking

Episode B - Follow the Flashlight

Purpose

Learner learns to track smoothly and to coordinate near and far point vision.

Entry Behavior

Learner can attend to novel stimulus, name familiar objects in his environment, and is not afraid of dimly lit room.

Material

Means of closing off direct light in room such as heavy curtains or shades. Flashlight.

Procedure

Facilitator explains to the learner that she is going to make the room dark and then use a light to find things around the room which the learner can name. Facilitator then turns out the lights and closes the curtains or shades. Facilitator turns on a flashlight and directs the beam along the wall and over the ceiling without shining it on any particular object until she comes close to the item to be "found." The beam of light then stops on that object, such as a lamp, table, or chair, and the facilitator says "The light shines on a" When the learner replies correctly, or when the facilitator has supplied the word because the learner has not responded after the pause, she then moves the flashlight slowly up the wall across the ceiling and then shines it on another object to be named, saying, "The light shines on the" and waits for the learner to reply.

Terminal Behavior

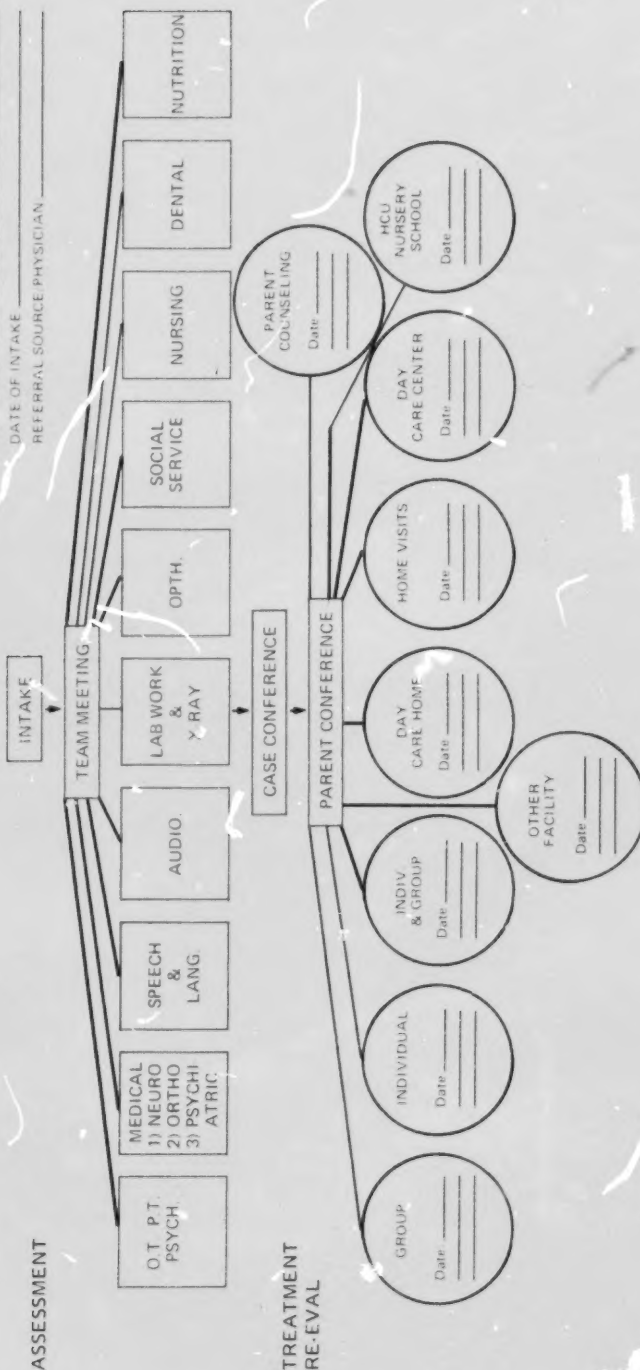
The learner follows the flashlight beam smoothly with his eyes and either names the item on which the light beam rests or repeats the name of the item after the facilitator.

The Goal is related to the overall developmental needs specified in the assessment/observation of the child. The Entry Behavior indicates the levels of skill which the child needs to perform the learning episode. Specifying an entry behavior prevents the child from experiencing failure at a learning situation too difficult for him. Skill levels for entry behaviors are known from assessment/observation. The Materials list allows the learning facilitator to prepare for the learning episode so that no interruption will occur when the interaction begins. The Procedure describes the interaction between the learner and the learning facilitator. The Terminal Behavior specifies the behavioral criteria which indicate that the goal of the specific learning episode has been approached by the learner. The SOL learning episodes presented in Volume IIR are not meant to be exhaustive and serve only as examples in various areas of functioning. The creative learning facilitator, once familiar with the nature and format of SOL can effect her own learning episodes based on the assessment of the child's abilities and observations of his moment to moment involvement and progress in the environment. Some children who learn more slowly may require a series of mini-goals and terminal behaviors within any given learning episode so that progress can be demonstrated through smaller, but no less significant steps.

The Early Assessment and Treatment Program at the Handicapped Children's Unit of St. Christopher's Hospital for Children utilizes the SOL in its varied and flexible program. This program has a transdisciplinary team consisting of an occupational therapist, physical therapist, language therapist, developmental psychologist, pediatrician, and child care worker. The team participates in the initial and ongoing assessments of a child referred to the program and, with the family, chooses a mode of service delivery which best meets the immediate needs of the child and family. Treatment modes available at St. Christopher's Hospital for Children include: full day care with a child care worker as prime learning facilitator in consultation with the other team members; individual treatment by a member with parent or team member as prime facilitator; group treatment with emphasis on parent becoming prime facilitator; home visits by a team member with emphasis on parent becoming prime facilitator; or any

combination of these treatment options as necessary. The accompanying flow chart outlines the options.

NAME _____
CASE MANAGER _____
HCU NUMBER _____
DATE OF INTAKE _____
REFERRAL SOURCE/PHYSICIAN _____



Initially, the team administers both standardized and criterion referenced tests to the child. Criterion referenced testing examines a child in terms of his ability to perform a given criterion behavior or to learn at a given criterion rate, as opposed to standardized testing which compares what he has learned in the past with what all other children in the norm population have learned over the same life span. Both forms of testing are necessary. Criterion referenced testing allows precise specification of goals and entry behaviors while standardized testing permits one to monitor the child's progress relative to age peers and so evaluate the program impact more fully. Accordingly, criterion referenced tests must be ordinal if they are going to yield effective use of the learning episodes by specifying sequential goals and entry behaviors for the child based on his manifest strengths and weaknesses. Likewise, the standardized test must be normed on a population relevant to the individual child and of a depth to monitor developmental gains over relatively short period of time. For example, in the cognitive area, the Bayley Scales of Infant Development (Bayley, 1969) are used as the normative measure and the Syracuse University combination of the Uzgiris and Hunt and Albert Einstein Scales of Sensory Motor Development (Honig, no date) are used for those children who are functioning at the level of Piaget's sensorimotor stages. Using these and other measures, the child's learning environment is specified by the team for use by the learning facilitator.

Training of learning facilitators, whether they are mothers or team members, consists of first alerting and sensitizing them to opportunities for entering into meaningful interactions with learners without intruding on and thus disrupting an ongoing learning situation. For learners whose level of interaction with the environment needs a higher level of input, the learning facilitator creates an environment which will engage the abilities of the learner enabling his own intrinsic motivation to develop. An example would be to redirect repetitive, self stimulatory activity using a learning episode which calls attention to the functional aspects of the body senses, has an entry behavior at a level which engages the child, reinforces meaningful sensory exploration, and allows for potential social interchange. The format of the SOL

Episodes permit relative ease of training of both team members and parents to be effective learning facilitators. There is no need for guessing as to whether a learning activity is appropriate since goal and entry behavior are specified. There is no guessing as to how to effect the learning episode since the procedure gives the methods. There is no need for guessing as to whether the learner has achieved the objective since the terminal behavior describes the criteria for making that judgement. Parents especially find the clarity of presentation most facilitative of their learning.

As the child engages in learning episodes and masters terminal behaviors, progress is recorded by means of the attached daily record of behavior on each learning episode implemented by the facilitator.

Achievement of the terminal behavior (5) on successive days and the continuation of the activity on his own, indicates that the learner has reached the criterion of performance. Therefore, the learner is ready to begin the next step indicated in the hierarchy of the criterion referenced test through a new specification of learning episodes of various kinds which will encourage the acquisition of new terminal behaviors showing progress toward the next goal of the criterion referenced test.

As indicated previously, at the St. Christopher's Hospital for Children program, the child's progress is also monitored by the periodic readministration of standardized tests covering all goal areas of the SOL. In this way, the child's progress is compared to the performance of his age peers which in turn provides an evaluation system of the SOL program effectiveness. Data is sparse as yet for this program since it has been in existence only six months, but those few children who have been re-evaluated formally by the team on both the standardized and criterion referenced measures are resisting the pattern of decline in relative level of functioning from the norm which the literature indicates may be expected of these children and are either maintaining a constant level of development or are showing gains. Further evaluation of SOL effectiveness is determined by comments solicited weekly from learning facilitator parents, associated child care workers, and team members who are acting as prime learning

Parent/Child Learning Episode (L.E.)

NAME _____ NAME OF L.E. _____
 DATE _____

<u>Monday</u>						<u>Tuesday</u>							
	Not at all			Very much				Not at all			Very much		
Pays attention	1	2	3	4	5	Pays attention	1	2	3	4	5		
Needs encouragement	1	2	3	4	5	Needs encouragement	1	2	3	4	5		
Gets frustrated	1	2	3	4	5	Gets frustrated	1	2	3	4	5		
Achieves skill	1	2	3	4	5	Achieves skill	1	2	3	4	5		
Continues on own	1	2	3	4	5	Continues on own	1	2	3	4	5		

<u>Wednesday</u>						<u>Thursday</u>							
	Not at all			Very much				Not at all			Very much		
Pays attention	1	2	3	4	5	Pays attention	1	2	3	4	5		
Needs encouragement	1	2	3	4	5	Needs encouragement	1	2	3	4	5		
Gets frustrated	1	2	3	4	5	Gets frustrated	1	2	3	4	5		
Achieves skill	1	2	3	4	5	Achieves skill	1	2	3	4	5		
Continues on own	1	2	3	4	5	Continues on own	1	2	3	4	5		

<u>Friday</u>						<u>Saturday</u>							
	Not at all			Very much				Not at all			Very much		
Pays attention	1	2	3	4	5	Pays attention	1	2	3	4	5		
Needs encouragement	1	2	3	4	5	Needs encouragement	1	2	3	4	5		
Gets frustrated	1	2	3	4	5	Gets frustrated	1	2	3	4	5		
Achieves skill	1	2	3	4	5	Achieves skill	1	2	3	4	5		
Continues on own	1	2	3	4	5	Continues on own	1	2	3	4	5		

<u>Sunday</u>						<u>Comments</u>						
	Not at all			Very much								
Pays attention	1	2	3	4	5							
Needs encouragement	1	2	3	4	5							
Gets frustrated	1	2	3	4	5							
Achieves skill	1	2	3	4	5							
Continues on own	1	2	3	4	5							

facilitators. Individual learning episodes themselves are consequently often revised. The relevancy of any one episode to a child's developmental and motivational needs will also have to be continually re-evaluated. In this way, the System of Open Learning remains itself an open system, responsive to its environment. The SOL curriculum, therefore, applies the theoretical underpinnings by which it strives to promote the learner's development to its own development.

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The Program described below has developed a variety of innovative techniques and materials for working with handicapped infants and toddlers primarily in center-based settings.

A Description of Intervention Strategies for Handicapped Infants and Toddlers

by

Mary Mostertz

Melissa Perot

Yvonne Arnold

The Infant Motivation and Parent Preparation and Reinforcement Program summarized below is sponsored by the Montgomery County Association for Retarded Citizens, Norristown, Pennsylvania. Begun in January, 1972, the program serves a maximum of 20 retarded and/or multi-handicapped infants and toddlers, and has reached over 80 children in the past four years. The chronological age ranges served are from birth to three years.

Three Phases

The severe lack of programs for this population caused the initiation and funding of this project which is designed to help prepare parents to meet the needs and demands of caring for their children.

The first phase, "Parent Education," provides a continuous series of weekly seminar sessions for parents of newly diagnosed mentally retarded and/or multi-handicapped children. A day in the classroom working with their own child is an integral part of the preparation program.

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Melissa Perot is an Occupational Therapist with the Early Intervention Project, Montgomery County Association for Retarded Citizens.

Yvonne Arnold, M.Ed., is a Diagnostic Technician for learning disabled children in the Philadelphia School System.

These sessions were based upon the needs of the parents and included the following:

- A. The Aspects of Mental Retardation
 - 1. Definitions
 - 2. Medical
 - 3. Psychological
 - 4. Educational
 - 5. Social
- B. Open and Free Discussion Periods
 - 1. General topics
 - 2. Specific areas
 - a. guest speakers
 - b. films
 - c. reading material
 - d. individual counseling

Emphasis is upon formalized learning situations to prepare parents for the structured teaching roles to be used with their infants and toddlers.

The second phase, "Education of the Infant in the Home," is a continual, individually prescribed program which aims at fostering healthy social and emotional growth for the child, siblings, and parents. The program rests on the premise that the earlier a child is provided with a structured motivational program, especially during his initial developmental growth period, the greater will be his potential for cognitive growth and achievement. Gradual movement of the infants and toddlers from the home-based learning environment to that of the center is the primary goal of this phase.

The third phase, "Education of the Infant in the Learning Center," involves teachers, the developmental therapist, and the communication specialist. The teachers perform classroom procedures with the children during home visits. These give the infant and toddler a unique continuity of an individually prescribed program. Special skills and expertise are brought into the program through a Communication Specialist. Activities are planned to meet the individual objectives for each child.

Evaluation

Evaluation involves the initial assessment of the infant

and toddler using the Gesell Developmental Schedules, and the Uzgriris/Hunt - this is administered by the Occupational Therapist and Communications Specialist.

A conference is held with the parents following the assessment. From this assessment, an individual prescription, or recommended activities is written. A copy of this recommendation is given to the teacher and the parents. This assists in providing coordination between the home and school program, and promotes consistency and reinforcement for the infant/toddler.

The staff, under the direction of the therapists, implement the child's program and record behavior and performance daily. Observations of the infant/toddler's progress or lack of progress are noted and meetings are scheduled weekly with the consultants, staff, and program director.

Weekly meetings are also held with the staff and parents of each class to discuss the program and answer any questions or concerns. If necessary, an individual parent conference is held.

Objectives are determined from the developmental level and written for each child in the areas of motor coordination, communication, and adaptive behavior. These are presented to the infant/toddler daily, graded with a +/- and accomplished with a 3 to 4 week period. If the objectives are not completed within this time frame, they are re-examined and then either modified by breaking down the task further, changing the activities used, or introducing different/additional motivators.

A sample prescription of recommended activities follows:

Danny (Down's Syndrome)
B.D. 9/24/73

Date
O.T.

General Remarks: Danny has learned to sit up and lie down by totally abducting his legs. Prevent this when ever possible by bringing one leg into side sit position and reward correct movement.

GROSS MOTOR	PSYCHO/SOCIAL	ADAPTIVE
Tactile rubbing vigorously and with variety of materials (terry cloth towel, mit, etc.)	Name body parts. Encourage Danny to respond to simple commands such as "give me your arm or "lift up your leg."	Let Danny hold cloth and pull it away from him to hold on tighter. Let Danny pull off his socks.
* Large Therapy Ball all directions vigorously.	Make babbling noises. Imitate any vocalizations	
* Hammock - prone, supine and sitting, rock and spin		Encourage push and pull on your hands or hoop.
Barrel - prone, supine and straddling. Reduce assistance.	In front of mirror. Sing rythmical song.	
* Suspension - weight on hands, walk forward on hands, lower to prone and repeat.		Attractive toy on floor to "walk" to.
* Trunk rotation.	Round and round	Noise maker in one or both hands.
4 point crawl position - rock forward and back and side to side.	In front of mirror. Rock.	
Crawling.		Motivate him with bright or moving toy.
Jolly Jumper	Call his name, reward if he responds to name.	Noise maker in hand.
Side sit.	Say "in."	Encourage Danny to put small cubes or pegs "in" container.
* Staff Only		

Overview of Selected Equipment and Techniques

A. Equipment

1. Prone Wedge

This is a small triangular wedge shaped object made from foam or from wood covered with foam. It is approximately 4 to 6 inches high and 10 to 12 inches long depending on the size of the child. Straps stabilize the shoulders and/or hips. The wedge helps a child maintain the prone position for a time period in order to stimulate postural tone. For children with weak arms, the wedge enables them to reach for toys and to manipulate toys in front of them, or play in water, sand, and various media. This stimulates weight on extended arms.

2. Small Roll

This is a 2 foot section of heavy cardboard tubing between 4 and 6 inches in diameter covered with carpeting or terry cloth. It is used especially for children with flex or hypertonus in prone position to enable them to use their hands and to take weight on their arms. The child is placed over the roll so that it lies under his arm pits and is sufficiently forward so as not to restrict breathing.

3. Large Ball

This is a 36 inch diameter inflated beach or therapy ball. This is used for vestibular stimulation to promote head righting reactions in prone and supine positions. After appropriate introduction the child is placed on the ball, moved first forward and back, and then moved in a circular pattern to the left and right. The child is held at hips, knees, or ankles according to need, and the speed and extent of movement is individualized according to the child's reaction to stimulation. Initially, the head should come to mid-line, then some extension might be noted on forward push. This might be followed by pushing up on flexed arms then on extended arms. Finally, the child might reach for a suspended object with one or both

hands. In supine position, head flexion might be noted in response to stimulation as well as accommodation of head, trunk, and arms to circular movement.

4. Hammock

This is a net hammock both ends of which are suspended from one point so that the resulting loop is approximately one foot off the ground. A square of carpeting or foam rubber is placed in the loop to enable the child to be placed in the hammock more easily. Mats are placed under the hammock as a precaution. Its uses are: vestibular stimulation, promotion of increased postural tone, relaxation, and reflex inhibiting postures as well as reach and grasp activities. The child is placed prone across the hammock with his arms and legs extending beyond the netting and is swung in a forward and backward motion or spun. In the supine position, the head is supported by the hammock.

5. Barrel

This is a heavy cardboard container approximately 12 to 15 inches in diameter covered by carpeting. Used to promote protective extension as well as weight bearing to legs and arms, the child is placed prone and supine over the barrel and encouraged to push off from the floor with hands and feet. When he has some sitting balance, he may straddle the barrel and rock from side to side to promote balance reactions.

6. Foam Mat

This is a 6 by 4 foot length of foam, 4 inches thick. It is used to increase body awareness in rolling and belly creeping exercises and to stimulate equilibrium reactions in four point crawling and walking.

7. Ramps

This is a large wedge-shape ramp covered with vinyl, or a 4 by 8 foot sheet of plywood covered with carpet. The highest end is 18 inches off the

floor diminishing to 2 inches. When the child is placed at the top of the ramp, the force of gravity assists movement (rolling, creeping, crawling), down the ramp. When the child is placed at the bottom of the ramp and encouraged to move up it, the force of gravity resists movement thereby increasing the strength of that movement. For immobile children with respiratory difficulty, the ramps have been used for postural drainage.

8. Scooter Board/Crawligator

This is a square or rectangular board on casters. It is used to promote postural tone and weight on extended arms with increased mobility. The child is placed prone on the board. A single strap around his middle supports and maintains this position. The child is then pushed or pulled on the floor or encouraged to use his hands to propel himself.

9. Vestibular Board

This is a rectangular board on rockers, 60 by 30 inches. It is used to promote equilibrium reactions in lying, four point crawl position, and sitting. The child is placed on the board in the appropriate position, and is either rocked or rocks himself side to side or forward and backward.

10. Triangle Chair

This is a specially constructed chair described in Nancie R. Finnie's book, **Handling the Young Cerebral Palsied Child at Home**, with an additional tray attachment. It is used for the child who demonstrates poor hip flexion in sitting, stiffly adducted legs, and who pushes back with his head. The chair supports the hips in the correct sitting posture, abducts the legs, and brings the arms and hands forward into the child's line of vision to promote a more normal reach, grasp, and manipulation of toys.

11. Saucer

This is a large metal concave disc which is

sold commercially for sledding. It is used for vestibular stimulation and to stimulate balance reactions in lying, kneeling, and sitting. The saucer is spun or tipped in various directions in order to stimulate the appropriate responses.

12. Trampoline

This is a small 3 by 4 foot trampoline with rail at one end to grasp in standing. It is used to promote body awareness through kinaesthetic and proprioceptive stimulation. The child is placed in a four point or sitting position, bounced and then stood at the rail to bounce and eventually to jump independently.

13. Parallel Bars

This is used to encourage pulling to a stand through kneeling and half kneeling, cruising (walking sideways holding on), and walking forward and backward.

14. Eight Inch Balance Beam

This is used to encourage adducted legs in four point crawling, later in walking, and then to promote balance with mobility. Children are helped to walk forwards, backwards, and sideways. More advanced exercises include: keeping eyes on target, holding object in both hands, holding heavy object in one hand, and performing various arm movements while walking.

15. Steps with Rails

This is used to promote correct patterns in crawling and walking up and down stairs.

16. Large Climbing Frame with Slide

This is to promote body and spatial awareness, balance, protective reactions, and motor planning.

17. "Stepping Stones"/Tire and Ladder Walk

Stepping stones are 12 inch carpet squares placed at intervals on the floor. These are used to increase one-leg balance. The child is encouraged to step from one to the other. A higher leg lift is

required in the tire walk where the child is required to step in and out of tires laid on the floor. For the ladder walk, a ladder is placed on the ground. The child is required to place his feet between the rungs or to place his hands and feet in an elephant walk.

18. Mirrors

These are propped up in front of children in a prone position on the floor. This provides visual stimulation to promote head elevation and body awareness in finding and touching body parts.

19. Water Table

This is a table that holds water and has a depth of 6 inches. It is used to stimulate body awareness, head righting in prone and supine positions, weight on extended arms, amphibian reaction, and movement in both arms and legs. Squeezing, splashing, and pouring activities are performed either sitting in the table or standing in it.

20. Sand Table

This is the same as a water table but full of sand. It is used to promote body awareness particularly of hands and feet, and to develop appropriate play patterns of patting, scooping, pouring, etc.

21. Toys

These are a wide variety of infant toys and mobiles which may vary in weight, texture, color, shape, and noise making ability. These should be of a nature to stimulate reach, grasp, and manipulation for all levels of hand and cognitive development. They are also used in auditory and visual tracking exercises.

B. Additional Techniques

1. Stimulation

- a. **Tactile:** Stimulation to the skin surface makes the nervous system more receptive to subsequent stimulation. Discrimination and body awareness are also increased. The child is

rubbed over his entire body with a wash cloth, massage mit, soft brush, or other fabric. Body parts are named as they are rubbed in a downward pattern generally starting with the back. Body awareness games and songs may also be included. Special rubbing patterns are prescribed for children with imbalanced muscle tone so as not to increase hypertonicity and for tactilely defensive children so as to diminish withdrawal response. Children are encouraged to wear a minimum amount of clothing during activities so as to maximize tactile input. Hands, feet, and face are generally emphasized.

- b. **Vestibular:** This stimulation is used primarily to promote postural tone and righting reactions. In addition to the equipment described in the previous section, a number of carrying and swinging positions are suggested where appropriate.
 - c. **Proprioceptive:** This is used in weight bearing and joint approximation techniques; lying, kneeling, and standing to promote body awareness and enable locomotion.
 - d. **Visual:** Stimulation used to motivate children, to promote visual discrimination and eye-hand coordination on all levels.
 - e. **Auditory:** This is used to promote auditory discrimination, location of sound, as well as rhythm and sequencing. Language is used according to the Communication Specialist's recommendations based on the child's level of understanding and verbalization.
 - f. **Olfactory:** Stimulation used to introduce tastes and smell in the feeding program to promote acceptance and/or discrimination.
2. **Positioning**
- a. **Swaddling:** This is used to promote relaxa-

tion and relating. The child is wrapped in a blanket in total flexion, and is then held in care worker's arms and gently rocked.

- b. **Reflex Inhibiting Postures:** Examples of these postures are: side-lying for homolateral pattern, curling for total flexion in supine position, and heel-handing for total extension pattern.
- c. **Side-sitting:** This position is used to stimulate lateral protective reaction, trunk rotation, and adducted legs. (Down's Syndrome Children).

3. Movement Facilitation

These are only some of the more common exercises used to promote coordinated movement and to enable the child to move from one position to another (lying to sitting, sitting to creeping, etc.):

- a. **Head Rotation:** The child is placed in prone, supine, or sitting position. Auditory or visual stimulation is then presented first at the left side and then at the right side. The child is expected to turn his head independently of his body.
- b. **Trunk Rotation:** In the supine position, one leg is flexed and inwardly rotated so that the knee touches the floor on the opposite side of the trunk while the arm of the same side is extended and outwardly rotated. In the sitting position, the child is placed facing out between the worker's legs. The worker then holds the child around the chest and turns the child to face first the left side then the right side.
- c. **Rolling:** This is used to establish segmental rolling -- the child is rolled first with assistance at head and legs, then only at the head, and finally only at the legs. The arm over which the child rolls is extended next to his ear. The

head is then slightly flexed and turned over that arm. The opposite leg is flexed and inwardly rotated across the body. Timing is important and assistance is reduced as segmental rolling is developed.

- d. **Leg Flexions:** In the supine position, the child's legs are flexed to his chest and then extended back to the floor. This exercise is done alternately and reciprocally to develop independent coordinated leg action.
- e. **Pull to sit:** This is used to improve the child's head control. The child is pulled from a supine lying position by grasping both hands and encouraging him to pull himself to a sit while holding his head in line with his body. He is then lowered to the floor in the same way.
- f. **One arm pull to sit:** This is the same as above but the child is brought to a side sit by holding only one hand and encouraging the other hand to push from the floor.
- g. **Amphibian:** This is used to stimulate belly crawling. One hip is lifted off the floor. The leg of that side is expected to flex next to the trunk. Another method is that the arms are extended above the head, one shoulder girdle is raised from the floor, and the head extended resulting in the same reaction. This exercise is then repeated on the other side.
- h. **Four point rock:** This is used to promote four point crawling. The child is placed on hands and knees, rocked gently backwards and forwards, and side to side so that he feels the shift of weight on his extremities and learns to adjust his balance.

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The Early Intervention Project described in this article has been selected by the National United Cerebral Palsy Association for participation in their National Infant Collaborative Research Project. It describes some of the important concepts which have evolved from experience with a large number of developmentally delayed infants and toddlers, including Parental Involvement, the Transdisciplinary Team Approach, and the "whole-child" concept.

**New Beginnings: A Center-Based Training Program
for Families of Developmentally Delayed
Infants and Toddlers**

by

Claire Lapidakis

"New Beginnings . . ." an Early Intervention Project, operated by United Cerebral Palsy of Lehigh Valley, was designed as a program for families of young children with movement disorders. The Project was begun in 1971, and in January 1973, became associated with the National Collaborative Infant Research Project called Ripple. Ripple, supported by a grant from Bureau of Education of the Handicapped, included 15 centers located throughout the United States providing services to developmentally delayed infants from birth to age three. The purpose of the National Collaborative Infant Research Project was to accumulate information on infant programs and from this, design a curricula which would meet the needs of this population. One thousand infants were involved in this research and the results of this study have now been published.*

*The First Three Years: Programming for Atypical Infants and Their Families. United Cerebral Palsy Association, Inc., 66 East 34th Street, New York, New York 10016.

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The Developmental Model

Many of the concepts inherent in the program of United Cerebral Palsy of Lehigh Valley have evolved from the experiences of the Ripple Projects. The program is based on a developmental model rather than the disease oriented medical model and the teaching oriented educational model. The developmental model established program priorities as indicated by the child's developmental levels and the parent's needs. These priorities include psychological, physical, cognitive, and social needs. The **whole child concept** is the basic structure upon which this program is established. This whole child concept requires a team approach of parent and staff where specific knowledge is pooled and incorporated into the child's daily life. In this team approach, the main goal is for the parents as prime programmer of their child to understand and carry out activities which will minimize the child's deficits and help reduce the trauma that having a handicap child imposes on a family.

In planning for each child and his family the focus is:

For the Child: to minimize developmental delays through proper positioning, spontaneous play and exposure to normal developmental sequence in gross and fine motor, cognitive, self-help, language-feeding, and personal-social skills.

For the Parents: to increase parent's knowledge and understanding of normal growth and development and of their child's handicap. Parents must be trained in proper techniques of caring for their child so they can experience success in parenting – a reward every parent-child relationship needs.

The Transdisciplinary Team Approach

A new type of team approach was developed as a result of this research project. It is called the transdisciplinary model and it refines the team approach to early intervention. This approach requires a mature staff willing to share their knowledge without feeling threatened and to seek help when needed without feeling inadequate. This transdisciplinary model is based on the fact that an infant cannot integrate

multiple care giving experiences. In order to meet all needs of the child and keep the handling of a child to a minimum, each team member is trained to carry out a child's total program. No team member relinquishes his particular expertise but rather shares his knowledge with other members so each is knowledgeable of the total needs of the child. Technical assistance is provided whenever it is required by a person with training in the appropriate discipline. The team is responsible for the child's program. Flexibility of staff in relinquishing traditional professional roles while maintaining responsibility for the child's progress is significant for successful involvement of parents in the program as part of the team.

The Parent As Primary Facilitator

It is important that staff through training help parents develop confidence in their ability to cope with their handicapped child. Confidence and ability to cope will never take place if parents are led to believe that only those "specially trained" are qualified to intervene on their child's behalf. Professional staff have a responsibility to make parents of handicapped children "specially trained" so they are not totally dependent on others to meet their needs and those of their involved child. It is, therefore, essential for parents to be involved in the program designed for them. It is not enough to have an infant dropped at a center for staff to "do things at." This time is insignificant if during the time when the child is not in program, he is being improperly handled. It takes a great deal more staff energy to deal with both infants and parents at the same time, but the traditional way of working with older children without their parents present cannot be applied to the infant population. There are still strong attachments and separation problems between infants and parents which have to be taken into consideration in working with this age group.

Implementing the Program

Most often, parents first suspect their child is not developing properly when their child fails to reach a motor milestone such as holding head erect, rolling over, sitting, crawling, or pulling to stand. These are obvious deficits which are noticeable, but there may be and usually are other deficits

present which are not as obvious. In developing an intervention program, the total needs of a child and his family cannot be emphasized enough. The motor deficit is certainly an important aspect of the program, but there are many other areas to consider. Make sure the child's vision and hearing acuity are known. An assessment of an infant's mouth is also essential. Children with upper motor neuron lesions often have sensory disturbances in their mouths which manifests themselves by a lack of tolerance for any textured foods, and/or an inability to discriminate tastes. The gums should also be assessed, especially in children on anticonvulsant drugs, where hyperplasia can create very sensitive gums. Language and cognitive abilities can be determined through a variety of available evaluations such as the REEL, Portage Project, Wabash, Denver, etc. The Milani-Comparetti assesses spontaneous behavior and evoked responses. Fine and gross motor activities should be determined and the presence of primitive and/or pathological reflexes should be noted. The child's tactile system should also be evaluated during this time. This should include all extremities, trunk and face including the mouth. Tactile defensiveness often originates in a sensory system which is not intact and able to properly process incoming information. The child's ability to make attachments and/or indiscriminate attachment, affect, separation anxieties, etc. should be determined through proper testing and observation. The parent's feelings and attitudes towards their child should also be observed during this time.

After all these assessments have been made, a program can then be developed to meet the needs of the child and the family. The results of these assessments should be shared with the family. Emphasis should be first on what is right with the child, then what areas are deficit and finally how a program can help minimize these deficits.

The premise that "every child deserves a chance to develop to his fullest potential" should be the long range goals of every early intervention program. Many short range goals must be set and reached before the ultimate is achieved. Programs of early intervention can give infants and their families the opportunity to gain more normal growth and development before abnormal patterns are established. More and more, evidence accumulated from various infant pro-

grams shows that these programs are instrumental in helping children and families to be less handicapped.

The center-based Early Intervention Project described below is a replication of the Regional Intervention Project (RIP) in Nashville, Tennessee. Designed to serve young children with behavioral disorders and their families, it follows the modular concept of RIP, utilizing trained parents as principal change-agents for participating children.

**Early Intervention Project for
Behaviorally Disordered Preschoolers**

by

James J. Reisinger and Fran Gray

Key issues in programming for mentally handicapped children are parent involvement by incorporating the parent in the therapeutic and educational process; accountability to the consumer; and mainstreaming by integrating or reintegrating the exceptional child into the regular classroom environment.

Since its beginning in 1973, the Holy Spirit Hospital Early Intervention Program (EIP) has attempted to incorporate these issues into a basic framework.

A replication of the Regional Intervention Project (RIP) in Nashville, Tennessee, EIP developed in reaction to the sparsity of programs for the behaviorally disordered preschooler in Central Pennsylvania. Utilizing the modular concept developed by its prototype, as well as the overall strategies of measurement and accountability to the trained consumer parent, EIP provides intensified therapeutic services.

The population served by EIP is made up of children from 1.5 to 6 years. Families enter the program from a diverse referral base extending from pediatricians to self-initiated inquiries. The diagnostic classifications have included "hyperkinetic reaction" and "unsocialized aggressive

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reaction of childhood", among others. Such classifications accompany a child entering EIP, but subsequent treatment avoids label references by adopting a focus upon behavior appropriate and necessary in the community. By tracking behavior change throughout EIP training phases, child progress is continuously measured and documented for staff as well as for parents.

EIP is made possible by a grant from the Office of Mental Retardation, Department of Public Welfare, and support received from tri-county area of Cumberland, Perry, and Dauphin Counties. EIP is not a fee-for-service agency. While parents do not pay for treatment, they do make a commitment to repay time. A parent repays 5 hours for every 1 hour of treatment. As a result of this time repayment policy, parents comprise the main manpower resource. Trained parents, under the supervision of professional staff, become the principal agent in changing the child's behavior.



The continual flow of parents into EIP allows for parents to first receive services and then assist in the delivery of similar services under professional supervision.

The EIP professional staff is comprised of 3 Master-level and 1 Bachelor-level persons. They serve as resource personnel and represent the disciplines of psychology, education, and speech. Aside from a secretary, all other positions are part-time and occupied by trained non-professional parents and volunteers.

The service structure of EIP is divided into distinct segments termed "modules." Each module, segment of the system, is intended to perform a specific function in accord with the individual child's needs. Subsequently, a child and parent may proceed through one or all modules, as determined by staff assessment and by family needs.



The **EIP Intake** provides families with an opportunity to discuss program requirements, to see actual treatment sessions, and to discuss EIP with other parents already receiving services. Simultaneously, this occasion allows staff to assess parent-child interaction and to secure further definition of the primary difficulty. With a decision as to a first priority for a child, entry will proceed to either the Individual Tutoring or Toddler Management Module.

Toddler Management deals with children whose behavior is characterized by tantrums and unmanageability. Although some of these children display biological influences, organic impairment is seldom the predominant causal factor of their behavior pattern. In this module's operation, parents and child participate in twenty minute structured play situations. Through the treatment stages of Baseline, Intervention I, Reversal, and Intervention II, the parent-child interaction is analyzed by ongoing data collection. The parent is effectively taught to promote cooperative and to demote uncooperative child behavior. These procedures are so designed to teach parents what to do at home.

Individual Tutoring is intended to produce functional

speech in the child by means of training his parents to teach him and also to directly increase his repertoire of adaptive behavior. Depending upon the child, treatment may begin with eye contact, motor imitation, vocal imitation, verbal imitation, naming of objects, or more complex tasks. The child's mother begins by learning to record data on her child's progress. Within a few sessions mother becomes the teacher. After she has gained confidence in teaching her child, she may begin to teach him at home each day. She may also then teach her husband as she herself was taught by starting him on scoring home sessions. The child is now learning at home while his mother demonstrates progress and confers on procedures in the clinic as determined by her own and her child's needs. Once skilled in these procedures, many parents cannot only teach skills like toileting and dressing, but habitually abide by the rule for generalization of learning: "any desirable behavior that the child learns anywhere is thereafter required and reinforced everywhere."

As needs dictate, a child who has completed individual treatment sessions may enter the **Intake Classroom**. The teacher then assumes case responsibility for the family and conducts a nursery-level instruction program. However, while instruction is the format, emphasis is placed upon appropriate peer interaction. As basic self-control competence is developed, a child is proven eligible for the next classroom level.

The **Deficit-Remediation Classroom** is operated on the assumption, allowing for maturation, variations, etc., that these children either display typical parallel play and/or cooperative group behavior. The focus is now definitely educational, with individualized programs and objectives stipulated and measured daily for all children. The program is intended to improve skills in areas such as gross and fine motor control, color and form discrimination, and speech.

The final educationally based oriented program is maintained in the **Community Classroom**. Children are taught a mastery of basic skills in accord with age, maturation level, existing preschool standards, etc. This class employs minimal control techniques and is intended as a transitional parallel to interface with many preschool class programs available in the community.

The primary function of the **Liaison Module** is returning the child to the mainstream. This module accepts responsibility for the family as the next step may include assistance in placing a child in the community. The Liaison personnel mainstream a listing of placements appropriate for various children. They consult with families on available systems and investigate possible placements. As well as coordinate continued home teaching programs begun by other modules, they also actively assist a teacher in programming for the child placed in her nursery or kindergarten class. They conduct periodic surveys of children no longer primarily served by EIP. Should the family encounter further difficulties, Liaison is the link back to EIP support or intervention systems. Through Liaison, EIP can maintain an open-ended, reciprocal commitment with all families served.

There are a number of ancillary modules including a **Nursery**, staffed by trained parents, where infants are cared for while parents are involved in another segment of the program. **Parent Theory Class** is intended to teach parents the theoretical basis of the techniques utilized daily. It also provides the working parent with an opportunity to become involved in the clinical program experience of the child. Other supportive modules utilizing the talents of trained parents are **Public Relations**, and **Volunteer Training and Research**.

EIP also uses outside psychological and educational consultants to critique the program in a variety of aspects. These involve evaluations of a comprehensive nature as well as evaluation of specific module procedures. Information from the consultants is made available to program staff, the County, and the Advisory Board Committee.

The Holy Spirit Hospital EIP Advisory Committee may become involved in recommendations concerning program evaluation. The Committee is composed of 50% parents who have received EIP services and 50% interested community persons (e.g., special education principal, attorney, home-maker).

The Committee meets at least once a month. It may request any information from the program, evaluate that information, and render a binding opinion regarding adequacy of program results. The basic questions that will be asked are

communicated to the Program Coordinator in advance of the meeting date. The Coordinator is responsible for demonstrating adequate program results to the Committee, usually in terms of measured child and family progress. The Coordinator, however, retains full authority over the conduct of operations or the manner in which results are obtained for the Committee. Therefore, program personnel are free to develop their own methods and styles of achieving results, but the system is accountable in terms of results to those it serves.

This Committee evaluates EIP independently of the program staff. The procedure is basically this: when a mother and child complete their involvement in EIP, a follow-up questionnaire is sent to them. The results are received directly by the Parent Advisory Committee. In this way, parents communicate with parents concerning pros and cons of EIP programming and avoid biasing effects that may result from an evaluation conducted by professionals. The Advisory Committee periodically informs professional staff of consumer reactions and thereby recommends operation changes. The staff may make necessary changes which are deemed feasible and essential, but the Parent Advisory Committee will supply continual evaluation by consumers regarding adequacy of those changes. EIP incorporated the identified concerns of parental involvement, accountability to the consumer, and mainstreaming into its basic framework.

The primary emphasis of the Early Intervention Program is the general reduction of behavior problems in young children and an increased parental awareness of the needs of their children. Designed to serve families, the prime manpower and evaluative resource of EIP is the trained parent. The parent, utilizing learned child-rearing skills and their behavioral applications, shapes her child's development during daily interaction. The future of EIP is contingent upon parent involvement. As more parents come from services, the resource for that service provision increases.

Unlike the traditional schedule of therapy hours, EIP offers an intensified program. EIP provides service for 4 full mornings per week to facilitate parent-child learning through exposure and practice with technique applications. Most families can complete their individual sessions in 4 to 6 weeks, and have usually had sufficient experience to both under-

stand and efficaciously apply procedures. Through generalization, the child now behaves appropriately in environments where before he was a behavior problem.

The Holy Spirit Hospital Early Intervention Program assists parents and their children in remediating behavior problems so that the child's behavior is acceptable within his environment.

The Westmoreland County Association for Retarded Citizens' Early Intervention Program was among the first to be established in the State. After several years experience, the Project has evolved into a multi-faceted one, with particular emphasis on flexibility of model to meet the needs of the child/family.

A Multidimensional Early Intervention Program Model

by

Kathryn O'Connor

The Westmoreland County Infant and Toddler Stimulation and Parent Education Project is an early intervention program designed to service children, 0-5 years, with a developmental disability. The Westmoreland County Chapter of the Pennsylvania Association for Retarded Citizens is the local agency which sponsored the project.

Philosophy is often a nebulous academic concept. However, philosophy is a crucial aspect of the Infant and Toddler Project. Children who are labeled as mentally retarded are children first and foremost. Their humanity is not defined in the categorical, academic term of mental retardation.

Every child has a potential to be actualized. That potential may cover a broad spectrum of skills, from the child who moves his head six inches to one who is mastering primary reading skills. The "level" of the skill is not important. Just as much professional effort is expended on the child who is working to develop head control as the effort expended on the child who is striving to master prerequisite reading skills. Each child is an individual, to be educated according to his uniqueness.

"Education" can be defined as the development of survival techniques. If a child is unable to suck, his educational curriculum will include activities to facilitate sucking. If he is unable to walk, education will include movement activities in the gross motor area. The job of the educator is to identify a need and find a way to meet that need. Many disciplines

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are valuable resources to utilize. The physical developmental specialist, occupational therapist, and speech therapist are professionals who have a very valuable input to our program.

The most important element in any program is the individual child. Needs are assessed and an appropriate program is written. If the needs of the child are not congruent with the expertise of the staff, the child is referred to professionals who can meet the specific needs of the child.

The project currently services 47 families. The staff consists of Teachers, Teacher Aides, Social Caseworker, and consultant Physical Therapist, Occupational Therapist, Speech Therapist, and Sensory-Motor Specialist.

The Infant and Toddler Project is multidimensional. The specific segments of the program include:

1. Developmental Preschool Center
2. Integrated Preschool
3. Home-Bound Program
4. Counseling Program

The Developmental Preschool is in session Monday through Thursday from 8:30 a.m. to 3:00 p.m. The objective is to work with children to facilitate normal developmental skills. If, because of a neurological deficit, normal development is not possible, the objective is to inhibit abnormal reflex movements to facilitate more normal movements.

Although the program is developmental in nature, the *total child* needs are discerned before a program is written or implemented. The sole objective of the Infant and Toddler Stimulation Project is not only for the child to acquire skills. The broad base of the project attempts to integrate needs other than those which are purely programmatic.

When a child is referred to the Program, the social worker visits the home to acquire basic knowledge regarding the child's needs as well as to ascertain family concerns. A battery of developmental tests are administered to determine the functioning level of the child and assess the appropriateness of our program for the child. Alternatives are explored - other more appropriate community services for the child, home-bound program, center-based program, or integrated preschool. A decision is reached jointly by the parents, social worker, project director, and head teacher as to the best possible placement for the child.

If the child should be placed in our program, the results of the Developmental Tests are reviewed:

Hart Developmental Evaluation
Denver Developmental Screening Test
Receptive-Expressive Language Test (R.E.E.L.)
Neurodevelopment Reflex Test

The functional capabilities of the child are determined in relationship to a continuum of skills. Individual instructional objectives consist of a profile sheet which lists the various skills that the child is being programmed to acquire. Next to each specific program is recorded an entry date which denotes the time and specific activity number of the skill.

Each program is concerned with a finite skill. That particular skill is broken down into various components necessary to program the skill. A child could conceivably be working on 25 programs, each program with 20 sub-activities designed to facilitate that one program goal. The profile sheet could be a visual representation of 5 programs or 25 programs, each with activity skill analysis.

Several children may be learning the same skill program; however, with the sub-activity division, all will be working on different activities to acquire the same finite skill. Each child performs specific activities according to the developmental capabilities of he, the individual.

The Individually Prescribed Education Program for each skill is possible because of the developmental sequencing of the tasks involved in acquiring a given skill. A task analysis is performed on each skill that a child is learning. The activities correspond to the breakdown of each skill. The first activity in a program would be the least difficult task to perform. The objective is that the child will independently acquire each specific skill.

Along with developmental programming, there must also be a concern for the medical concomitant disability of each child. A high percentage of the children in our program experience abnormal reflex activity and medical involvement. For this reason, a Registered Nurse is on staff, functioning as a teacher. Her input is critical. A child must be physically able to attempt to master a skill. It is the responsibility of the nurse-teacher to determine that capability for each skill

as well as child. The nurse-teacher must educate the other staff members as to the needs of the medically-involved child.

Each child is evaluated by a physician who is familiar with developmental activities occurring at the center. The physician is responsible for deciding if a child who is being tube fed should be placed over a cage ball, or if a shunt could become dislodged by a developmental activity.

A second orthopedic physician must prescribe, in writing, physical therapy for each child. It would be the responsibility of that physician to determine if a child with a chronic dislocated hip should be placed in a corner chair or a standing board.

Medical questions are a constant source of concern to all staff members.

A second aspect of each child's educational curriculum consists of the consultant's prescribed programs and activities. Each child is assessed by the Physical, Occupational, Speech, and Sensory-Motor Specialists to determine the developmental functioning level of each learner. However, these assessments are specific to a given area of development. The Physical Therapist's services are concentrated upon children who experience reflex and motor involvement as well as major medical concomitant disabilities. The objective with many children is to position the individual child so that abnormal reflex movements can be inhibited to prevent contractures and body disalignment. The Occupational Therapist concentrates upon the eating skills of all children, and behavior problems. The Speech Therapist's services are concentrated on the receptive and expressive skills of all children.

Each therapist completes an assessment, and from that assessment prescribes specific activities to be implemented for that child. The activities are prescribed to enhance functioning that can transfer to many skills.

Each Friday, teachers travel to the homes of children in an effort to bridge the inevitable gap between home and center. Parents are a crucial aspect of our program. Professionally, we as a staff have accomplished very little if we are unable to teach parents how to implement developmental activities with their child. We have failed professionally if we are unable to transfer a certain expertise possessed by the staff to the parents. For it is the parent who assumes the

total responsibility for their child – not the professional. It, therefore, becomes our responsibility to equip the parents with survival knowledge.

Each teacher has a caseload of children who are relevant to her strengths. In the home visits, attempts are made to learn from the parent what behaviors the child displays in the home, as well as emphasize the parent-teacher implementation of developmental activities. The visits are learning sessions for parents and teachers alike.

The Home-Bound Program is a developmental program implemented only in the home. The child is not transported to the center because of a major medical problem. For example, it would be dangerous to transport children who are being tube fed to the center. Therefore, a teacher travels to the home. The above exploration of the developmental preschool is an appropriate description of the program for a home-bound child. Therapists travel to the home when their input is needed. However, only one teacher works with a child in the home. The staff members of the Infant and Toddler Project are involved in the program because of a specific strength. Their expertise is unique to the individual.

The Integrated Preschool Program occurs with an existing community program. When a child has acquired certain individual and group skills, an assessment is made to determine the functional level of the preschool child in comparison to normal children at the same chronological age. This assessment is completed to consider the possible integration of the handicapped child within a normal preschool environment. It is necessary that the child has certain prerequisite skills vital to appropriate interaction with peers. All children learn from one another through their interaction and observation of one another. The modeling of normal peer behaviors is essential to the socialization and normalization processes. For an integrated preschool.

The center in which we integrate our children has an already existing curriculum in which our children are assimilated. However, a teacher from our developmental preschool accompanies the children to the integrated program. It is her responsibility to ensure developmental programming as well as peer interaction and socialization. Hopefully, the child receives the best of both worlds – a developmental curri-

culum and a daily opportunity for peer interaction and the modeling of appropriate behaviors.

Parent Education

Each child participating in the Infant and Toddler Program is a unique individual with his/her own personality structure, potential, strengths, and weaknesses. So too is each child a viable member of a family. In order to meet the individual needs of the child, the needs of his/her family must also be serviced as the parents are generally the child's major resource. Consequently, parent education is an integral facet of the program.

Upon entrance into the program, each family has its own unique perceptions of mental retardation, how it relates to their child, and its impact upon the entire family structure. It is imperative to relate the family at the level where they are functioning. The program incorporates the parents as members of a team approach for servicing the needs of their child. This can only be done effectively by establishing a rapport with the parents that will elicit their goals and feelings for their child and must continue on an ongoing basis during the child's involvement in the program. Parent Education has many facets including supportive services, advocacy, information-giving, affective awareness and expression, and long and short term goal planning. All of these are imperative if the child is to develop to his/her maximum potential and be integrated in the family and community in a normalized manner.

Procedures for implementing these activities occur on three levels:

I. One-to-One Relationship

The family's initial contact with the center begins with a home visit from the social worker. At that time, the family is made aware of the services provided by our program and the involvement that is expected of them. A social history is taken and release forms for medical information signed.

The next step is a visit to the center for the child's initial evaluation by the Project Director. At that time, three evaluative instruments are used: The Hart Developmental Checklist, the REEL Language Scale, and the

Denver Developmental Test. The results of evaluations are then discussed with the parents that they may have a clearer understanding of where their child is functioning. They then meet with the staff and are given a tour of the center. Plans are made for the type of program to be implemented for the child (center or home-bound) and the frequency of the program (number of days).

Following this, the parents are visited in their home by the social worker on a monthly basis. These visits may be more frequent depending upon the family's needs. These visits provide the parent with a non-threatening environment in which they may explore any feelings or concerns they are experiencing in relationship with their child.

II. Group Experience

It is mandatory that at least one parent per family attend one group meeting per month. The parents are given a choice of three different group experiences and are free to select the one that is most beneficial to them.

1. Lecture Series - Each month an expert addresses the parents on specific aspects of developmental delays and/or their effect on their child or the family. The main goal of this meeting is dispersal of information. Speakers include genetic counselors, health and life insurance representatives, pharmacists, physical therapists, Mental Health/Mental Retardation Specialists, Right to Education Compliance Officers, etc.
2. Group Experience - This group meeting is less structured and focuses more on the unique experiences of the program's parents. It provides them with an opportunity to share their thoughts and concerns with each other thus engendering peer support. Parents become participants rather than observers in this group. Programs for this group include role playing, sensitivity exercises, etc., and are geared to the affective as well as cognitive levels of its members.
3. Mother's Group - The main caregivers for the children in the program are the mothers. Therefore, they are faced with the day-to-day responsibilities of their children and have specific needs intrinsic with this

role. The Mother's Group is designed to meet these needs. It is the most informal of the three groups and its presentations include sibling relationships and mental retardation, facilitative bathing techniques for the physically involved child, nutritional and hygiene services, budgeting, field trips to state or private institutions. This experience provides the mothers with information as well as peer support.

The Mother's Group meets in the afternoon while the first two groups are scheduled for evenings. Baby sitting and transportation are provided for all three groups.

III. Parent Conferences

Parent conferences are scheduled semi-annually for each family. At that time, the Project Director, Head Teacher, Home-Bound Teacher, and Social Worker meet with the child's parents to discuss the child's progress, present needs, future goals, and familial concerns. This team approach attempts to evaluate and maximize both parental and professional efforts in responding to the total needs of the child.

Educational curriculums for skill development are essential for normalcy to occur. However, all educational efforts fall short of their potential if parental involvement is absent. With the implementation of home visits, group experiences, and parent conferences, the parent becomes a participant in the normalcy process rather than a spectator. This not only enriches the child's educational experience, it encourages parents to be informed, aware, and responsible decision-makers for their child throughout his/her life span.

Through this multidimensional approach, the Westmoreland County Infant and Toddler Stimulation and Parent Education Project attempts to respond to the needs of the total child and his/her family. In order to provide this effectively, flexibility in programming, consultations and ancillary services are mandatory. Thus, an ongoing process of identifying needs and evaluating the responding services is an imperative function within the program.

One of the recent major trends in Education has been toward integrating handicapped children with non-handicapped children. Based on the Principle of Normalization, the concept of the least restrictive learning environment is gaining wide acceptance in many projects serving preschool children. A variety of program models have been established for accomplishing this. This article describes one such model.

An Integrated Early Intervention Project

by

Anne Vogeding

The Valley Child Development Center is a State licensed preschool for normal children. The Center contains four brightly decorated, well furnished classrooms. A number of different learning centers are arranged in each room and at various times of the day, children may freely choose between materials and activities. The program is a structured one, however, periods of child-directed activity alternate with periods of teacher-directed activity.

The Integrated Early Intervention Project serves 40 handicapped children from birth to 5 years of age. A wide variety of handicapping conditions is represented within this population. Included are the moderately trainable and mildly mentally retarded, cerebral palsied, blind, hearing impaired, speech impaired, learning disabled and emotionally disturbed. Project personnel are dedicated to the premise that these exceptional children can receive specialized education within a normal preschool setting.

A ratio of approximately 25% handicapped and 75% normal children is maintained in each classroom. Decisions concerning placement of the handicapped are made on an individual basis. Chronological age, developmental age, social behavior, and physical size are carefully considered in each case. Two major questions are always asked prior to placement:

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1. Will the activities taking place in this room be of any benefit to the development of this handicapped child?
2. Will the presence of this handicapped child hinder the participation of other children in any way?

It is seldom possible to match children perfectly. An example of this was the recent enrollment of Susan, a 5 year old, moderately retarded child. Although developmentally at the 18 month level, Susan could not be placed in the Center's Infant/Toddler program due to physical size and aggressive behavior. A decision was made, therefore, to place her in one of the Center's two rooms for 3-4 year old children. The larger, less structured room was chosen as it was felt that the activities in this room would provide greater opportunity for the learning of appropriate social behavior and self-help skills.

An individualized special education program was then planned for Susan on the basis of criterion-referenced testing of gross motor, fine motor, cognitive, language, socialization and self-help skills. Many of the special education goals chosen for this child were attained solely through the efforts of the non-Special Education teachers and the example set by normal children in the room. At various times during the day, however, special education support personnel were needed to enable Susan to participate meaningfully in large group activities with normal children.

A part of each day is devoted to small group activities which are planned for all children at the Center. At this time, Susan was placed with children of similar ability and needs. To remediate a severe language impairment, Susan received speech therapy on a daily basis. Regular one-to-one instruction was also necessary to insure the development of certain cognitive skills which could not easily be learned in any other way.

Although several specially designed prescriptive education and therapy rooms are available at the Center, it was possible to provide almost all of Susan's special education programming in the regular classroom situation.

The Valley Child Development Center's program for all handicapped children is similar to the one planned for Susan. Variations occur only in the amount and type of support which is needed to educate the exceptional child in a normalized setting. See Figures 1 and 2.

Figure 1: Integrated Special Education Program Model



Normal Education Program

Child participates fully in normal program - no support is needed.



Normal/Special Education Program

1. Child needs support to participate in normal program activities.

2. Special education activities are conducted within normalized setting.



Special Education Program

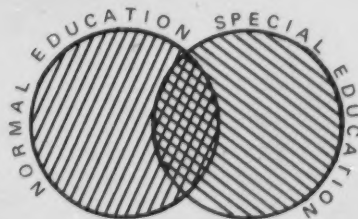
Child must have special education instruction outside the normal classroom to attain skill.

Figure 2: Sample Program Variations for Individual Children

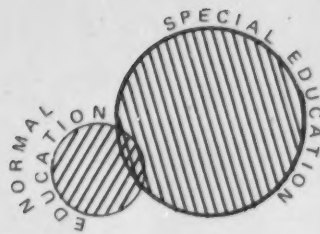


Child A

(Mildly Handicapped)



Child B

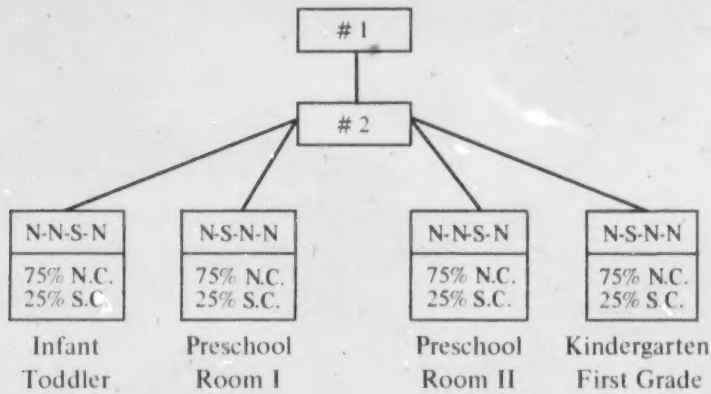


Child C
(Severely Handicapped)

Factors Facilitating Integration

The successful mainstreaming of handicapped children at the Valley Child Development Center is due primarily to the successful integration of staff members and special education resources. Special education support personnel are placed in each room of the Center as permanent staff. The Project's Special Education Director serves as a resource person to all teachers in the Center. See Figure 3. As noted in the case of Susan, many of the skills taught to the handicapped child are taught by the normal classroom teacher. The presence of Project staff members in each room enables the Center to maintain required special education staff ratios. Special education staff personnel do assume primary responsibility for evaluations and documentation of progress. However, all teachers share in the joys and frustrations of working with the exceptional child. There is no such thing as "your child" or "my child". The handicapped population at the Valley Child Development Center truly becomes "our children" to everyone.

Figure 3: Distribution of Children and Staff



- #1 - Program Director
- #2 - Director of Special Education
- N - Normal Education Personnel
- S - Special Education Support Personnel
- N.C. - Normal Children
- S.C. - Special Children

A second factor enabling successful integration of the handicapped at this Center is the program's balance between structured and non-structured time. An ideal moment to work with a special child on some particular skill is when all children are engaged in a variety of different activities. Then the special child becomes no different from any other child. He is doing his "own thing" just like all the rest of his classmates.

Many special educational goals are achieved during periods of small group activity. At such times, all children are divided into small groups for teacher-directed learning. The large size of each room makes it possible to separate these sufficiently to avoid distraction and generally one group of children is unaware of what another group is doing. Thus, the handicapped child can be grouped briefly with other handicapped children without notice.

Center personnel have found careful grouping of children an effective special education tool at other times of the day as well. There appear to be endless ways in which chil-

dren can help each other without even realizing what they are doing. Thus, a shy child might be given a very friendly child as his partner on a walk to the playground. Occasionally, a normal child is even included in special education instructions for the handicapped which are held outside the normal classroom. Normal children generally like the extra teacher attention this involves and serve as good models for the exceptional child. This practice also insures that no stigma will ever become attached to the Center's small prescriptive education and therapy rooms.

Attitudes Toward The Program

The Valley Child Development Center opened its doors to the handicapped gradually and without fanfare. After two years of operation, solely with normal children, the Center obtained special education licensing and several exceptional children were enrolled without comment. The fact of the Center's Integrated Special Education Program did not become public knowledge until a year later when it was featured in a local newspaper. Reaction from parents of normal children attending the Center was either noncommittal or very positive. Not a single normal child was withdrawn. Most parents had been unaware of the presence of any handicapped children at the Center, although one of these youngsters was a Down's Syndrome child. After almost three years of mainstreaming, the Center's administration is aware of only one incident of parental dissatisfaction with integration. This occurred when the mother of an educable retarded child expressed fear that her child would learn "bad habits" from a trainable retarded child whose locker was nearby.

The Center's normal children also seem unaware that there is anything "wrong" with some of their classmates. They may notice that an exceptional child has trouble doing certain things, but such a child is generally assumed to be younger rather than defective. On occasion, simple explanations are given for obvious differences such as braces. The Center's only blind child attended for many months, however, before a few of the older, more alert children realized that he could not see.

Conclusion

Much attention has recently been given to the advantages of mainstreaming. The Valley Child Development Center's "Integrated Early Intervention Project" clearly demonstrates that special education programming for the exceptional pre-school child can be carried out effectively in an integrated setting.

It should be noted that this project includes the additional components of an "Infant Stimulation Program" for multiply-handicapped infants and a comprehensive "Parent Education Program." Support for the special child thus begins early in life and extends to other family members as well. This is in keeping with the Center's philosophy that integration alone is not enough for the handicapped.

The Early Intervention Project for twelve preschool children at the Lynch Home, is part of an overall residential program for twenty-three profoundly retarded, multiply handicapped children who, on admission, require skilled nursing care. Many of the children suffer from heart defects, degenerative diseases, chronic upper respiratory difficulties, and a wide variety of other problems. In order to meet the educational and social needs of such medically involved children in a community residential setting, four specific aspects of the total program are of prime importance: Administrative Organization, Staff Perception of the Child, Physical Setting, and Individual Program Planning. The article below addresses each of these areas.

**Educational Programming Consideration:
The Medically Involved Child
In A Community Residential Setting**

by

Henry H. Lynch and David R. Misner

The obligation of a residential facility to meet the needs of children extends over a complete day, every week, usually for a period of many years, and requires a complex organization and dedicated staff. Administrative organization entails the effective utilization of resources to meet an individual child's needs. Traditionally, management of residential facilities for the mentally retarded has utilized the so-called medical or hospital model. The assumption underlying the medical model, however, is that acute illness is involved, and that medical and nursing care can bring about recovery. Regulations governing residential facilities for the retarded, until recently, have maintained this approach, with administrative authority vested in the medical personnel. Societal perception of the residents of these facilities as "patients" was a natural, but inappropriate result of this structure. Mental

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Retardation as a measurable developmental deficit must be differentiated from acute or chronic health problems.

Contemporary professional standards generally recognize that, for the majority of mentally retarded people, the medical model, with its implicit association of mental retardation with illness, is inappropriate. The so-called developmental model is recognized as a more appropriate underlying principle for organization of residential services. While one may disagree over certain definitions of characteristics, it is widely agreed that a developmental model attempts to increase the complexity of an individual's behavior, and attempts to increase the individual's ability to control his environment. However, the Lynch Home accepts only children with associated health problems, and difficulty arises in attempting to balance medical and developmental needs.

To reconcile this difficulty, medical-nursing safeguards are incorporated into the developmental approach, modified individually for each child's strengths and deficits. All direct service personnel are responsible in a clear line to the Program Director who is a special educator. The registered nurses are further responsible for skilled nursing procedures, (e.g., tracheotomy care, nasogastric tube feeding), as well as for health monitoring, and a Head Nurse coordinates their specialized functions under the direction of the pediatrician. Since a registered nurse must be on duty on each shift, that person is also the immediate supervisor of the other personnel on the shift. A basic distinction is made between the nurses's professional skills as a nurse, and between the nurse's professional duties as a supervisor. There are two separate professional functions in the role of the registered nurse in charge of each shift.

The medical and nursing personnel participate in the evaluation team which sets goals and objectives for each child. The team, and not one discipline, controls the setting of the goals. The team includes at least the Program Director, a Teacher, a Therapist, a Nurse, and a Child Care Worker. However, the Program Director has the ultimate responsibility to the administration for each child's program plan. Not to be misunderstood, the medical and nursing evaluations are often of first importance in aiding the developmental progress of a specific child. For example, often a child enters the Lynch

Home suffering from dehydration and malnutrition, and nasogastric tube feeding is indicated for a limited time in order to build or restore the child's strength. Frequently, the child's problem with sufficient oral intake of food disappears when he or she has gained sufficient weight and strength. The pre-school teacher would work with the doctor, nurse and therapist to safely implement a program plan for such a child.

Regardless of a person's professional or paraprofessional training, staff attitude is critical in determining if a child in the Lynch Home will be viewed as a developing human being despite all obvious handicaps. It is impossible, for example, to ignore the increased head size of a severe hydrocephalic who has been denied preventive surgery for whatever reason. Many studies have demonstrated that pre-labelling often becomes a predictor for a child's progress, or lack of progress. The Lynch Home prefers to make errors on the side of over-estimating a child's potential, at least with the pre-school population. To avoid later frustration, care must be taken to explain to parents and staff that the setting of an ultimate goal does not guarantee that it can be achieved.

One of the most effective ways of fostering a positive approach to a child's development is to ask a staff person to consider himself or herself - with his or her measured normal intelligence - in the role of a specific child. If all that the "staff-child" did all day were to lie in a crib and look at a drab, white ceiling, what could that "staff-child" learn except: to look at a white ceiling? After years of such a life, would not a "normal" person test at the retarded level? If a specific child has a tonic neck reflex or an extension pattern, the "staff-child" is asked to thrust his head hard to the left or right, or backwards, and while in that position, to attempt to swallow. The staff person then understands the difficulty associated with eating meals that a child with such abnormal reflex patterns may experience. In more obvious ways, dressing a child in clothing appropriate for age, size, sex, and season will greatly enhance the chance that staff will perceive the child as a child first and as a handicapped individual second. The physical care needs of a child must of course be met: no one wants to interact with a child who has distasteful breath and rotting teeth.

It is also important to make allowances for differing times of the day, week and year. For example, it is more dignified for the child and more meaningful for the staff to assume that a child has some awareness of a holiday than to assume that the child has none. How else will a child in a residential setting learn to be aware of certain events unless he is given the opportunity by the staff?

The Lynch Home project operates in a converted home with safety modifications.



Mr. and Mrs. Thomas Lynch, the founders, and their family lived with the children from the beginning of the Home in 1934 until 1972. The physical plant looks exactly like a regular home and is located in the middle of a residential block in a suburban Philadelphia neighborhood. While the building has shortcomings, its location and layout encourage staff and the surrounding community to perceive 23 severely handicapped individuals as children living in a home. That is, the "building statement" reaffirms to the staff, parents and to the community, that this building, is, first of all, a home. A specialized building with long, wide corridors, excluded from a typical neighborhood, cannot possibly make that "building statement." Such a building would imply, however subtly, to children, staff and to all who are affected, that the occupants of the building are "special" and must be "protected." Locating a complex, medical-developmental service

such as the Lynch Home provides in the wing of a hospital or nursing home returns the children to the medical model and the not so subtle classification as "patients."

If administrative organization, staff attitudes and physical surrounding are coordinated to reinforce the purpose of a residential facility -- that is, to provide a highly structured, habilitative substitute home for individuals who cannot live in their natural homes -- then the program plans formulated by the evaluation team will likely be an effective method of coordinating the appropriate services to the individual child. The plan should be appropriate not only for the "normal" school day, but should extend over the entire day, week and year.

The first phase of developing the program plan consists of an in-depth evaluation of each child's functioning level as well as his or her medical needs and restrictions. This phase includes an evaluation of vision, hearing, reflex patterns, neurological dysfunction, suck-swallow sequence, physical health, and formal and informal assessments of developmental performance. The main purpose of these evaluations is to provide a baseline for developing each child's educational program.

The second phase consists of formulating an appropriate individualized program based on the initial evaluations. This process will include appropriate medical and nursing, physical, occupational and speech therapy recommendations and the development of behavioral objectives through task analyses commensurate with each child's functioning level. It is imperative that not only project staff but any person involved with the child, understand his or her part in insuring the success of the child's program.

In summary, the Early Intervention Project at the Lynch Home operates as part of a community-based residential setting. The complex needs of the children and the obligations resulting from the increased responsibility inherent in the residential setting require organized cooperation among the disciplines, and between professional and non-professional staff.

The First Chance Program and Child Development Centers (Head Start and Title XX Day Care), both programs under the Community Progress Council, have united to form a system which serves children, including those with special needs, from birth to age ten. This combined system can serve 365 children and of these, 140 may be children with special needs. It is with these 140 children and their place in the system that this article is concerned. The purpose of this article is to describe the First Chance Child Development Centers' System, its history, its present status, its future, and to provide a frame of reference to persons attempting to organize a community system for providing services to young handicapped children and their families.*

**A Community System for
Serving Young Children and Their Families**

by

Kathryn Sims

In 1972-73, an informal study was done by the Community Progress Council of services available to preschool handicapped children in York County (population, 215,000). The greatest need was for service to preschoolers with social and emotional problems. The two local agencies providing limited service to these children supported the submission of a proposal by the Community Progress Council for a three-year grant from the H.E.M. Office of Education, Bureau for the Education of the Handicapped (B.E.H.) for funding a demonstration preschool program for socially/emotionally disturbed children.

The First Chance Program's first B.E.H. funding year was October, 1973 - June, 1974. The first period of funding was for program planning and recruitment of staff. An Ad-

*Community Progress Council is a Community Action Agency federally funded by the Community Services Administration.

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visory Committee had been organized as the Head Start Advisory Committee for Services to Handicapped Children. In August, 1973, this Committee was made up of representatives of various agencies who were directly or indirectly working with handicapped children and their families, representatives from Child Development Centers' Overall Policy Council and Community Progress Council's Board. This Committee was directly involved in the beginning planning for the program and assisted in the hiring of a full-time director in February, 1974. Since the primary target population was children in the Child Development Centers, the director spent time training staff to work with children with special needs and to individualize their approach to all children. Two of those staff who showed special interest and ability were hired to work in the First Chance Center which began operation in the second year of funding, 1974-75. A third Child Development Center staff person was also hired, as was an Assistant Project Director. A student intern was later hired as a teacher and completed the staff.

During the second year of funding, the year of program implementation, the First Chance Program staff were influenced by training received through the Philadelphia Child Guidance Center. This training focused on Structured Family Therapy, a family therapy approach developed by Salvador Minuchin, M.D. The program made it an objective to involve total families, including siblings and both parents. Through this training, staff developed skills to guide families who might have special problems. The staff became advocates of the total family's rights and responsibilities in planning for their future. This family-centered approach permeated the whole system as it grew and expanded.

After recruitment within the Child Development Centers and through schools and other referral sources, the classroom opened September, 1974 with five children. This center, though especially designed to serve children with social/emotional problems, soon discovered many other problems. For example, one child who was thought to be a behavior problem was found to be deaf. These children could not function in a regular child development center, but the classroom was planned to help the child progress to a point where he/she could be in a regular class.

The third and final year of the B.E.H. demonstration grant began July, 1975. The program was refined and expanded to include a center-based project as well as four mainstream programs. In four Child Development Centers which serve as Mainstream sites, each is staffed with a First Chance Resource Teacher four mornings per week. This will later be discussed in detail.

During the Spring of 1975, the First Chance Program integrated two new programs. In April, 1975, the York County Association for Retarded Citizens, through the local Mental Health/Mental Retardation Board, was designated grantee for a pilot Early Intervention Program. A home-based program for developmentally delayed children, birth to age three was established. Later, in those areas with no local Child Development Center, the program was expanded to include children birth to age six. Through contractual agreement with the grantee and the Community Progress Council, the First Chance Program became responsible for the service delivery of the Early Intervention Program. The purpose of the three-month pilot program was to recruit families and to field test service delivery in an urban setting and a rural setting. Two teachers and a Supervisor of Child Development and Special Education were hired. Ten families were recruited who had children with varying degrees of need from severe retardation to children at risk for developmental delay. Each family was visited weekly in the home and after evaluation of problem areas, a plan of infant stimulation and activity was developed. In July, 1975, a full year grant for the Early Intervention Program to the Community Progress Council and First Chance Program was made by the State Office of Mental Retardation. The program was expanded to potentially serve 88 children and made service available to all of York County.

Also during the spring of 1975, the York-Adams Mental Health/Mental Retardation Board asked the First Chance Program to direct the preschool program then operated by the York County Association for Retarded Citizens. The York County Association for Retarded Citizens agreed to this since the Association was moving toward a role of community advocate and decreasing its role as a service delivery system.

Plans were developed for a program, and staff recruited and hired during the summer. The teachers made visits to the homes of returning students and to the homes of new students during the summer months. This gave the staff an opportunity to meet children and families and to better plan for the opening of school in September.

Present Program

As of July 1, 1975, the First Chance Program/Child Development Centers included the following programs with a potential to serve the indicated number of children:

Chart 1

1. School Age	5-10 years	45	Day Care
2. Goode/Noell	3-5 years	16	Home-Based and
		13	Day Care
3. Parkway	3-5 years	31	Day Care and
	3-5 years	5	Mainstreaming
4. McKinley-Cookes	3-5 years	30	Day Care and
	3-5 years	5	Mainstreaming
5. Hanover	3-5 years	36	Day Care and
(St. Marks)	3-5 years		Mainstreaming
6. Hanover	3-5 years	15	Day Care and
(St. Matthews)	3-5 years	5	Mainstreaming
7. Red Lion	3-5 years	15	Day Care and
	3-5 years	5	Mainstreaming
8. Kennedy Develop-	3-5 years	20	Severely Handicapped
mental Program			Mentally Retarded
9. Jefferson Develop-	3-5 years	12	Severely Handicapped
mental Program			Social/Emotional
10. Early Intervention	0-3 or	88	Home Based
	5 years		

*The number of children in Day includes children with special needs who can function in the center without the Resource Teacher.

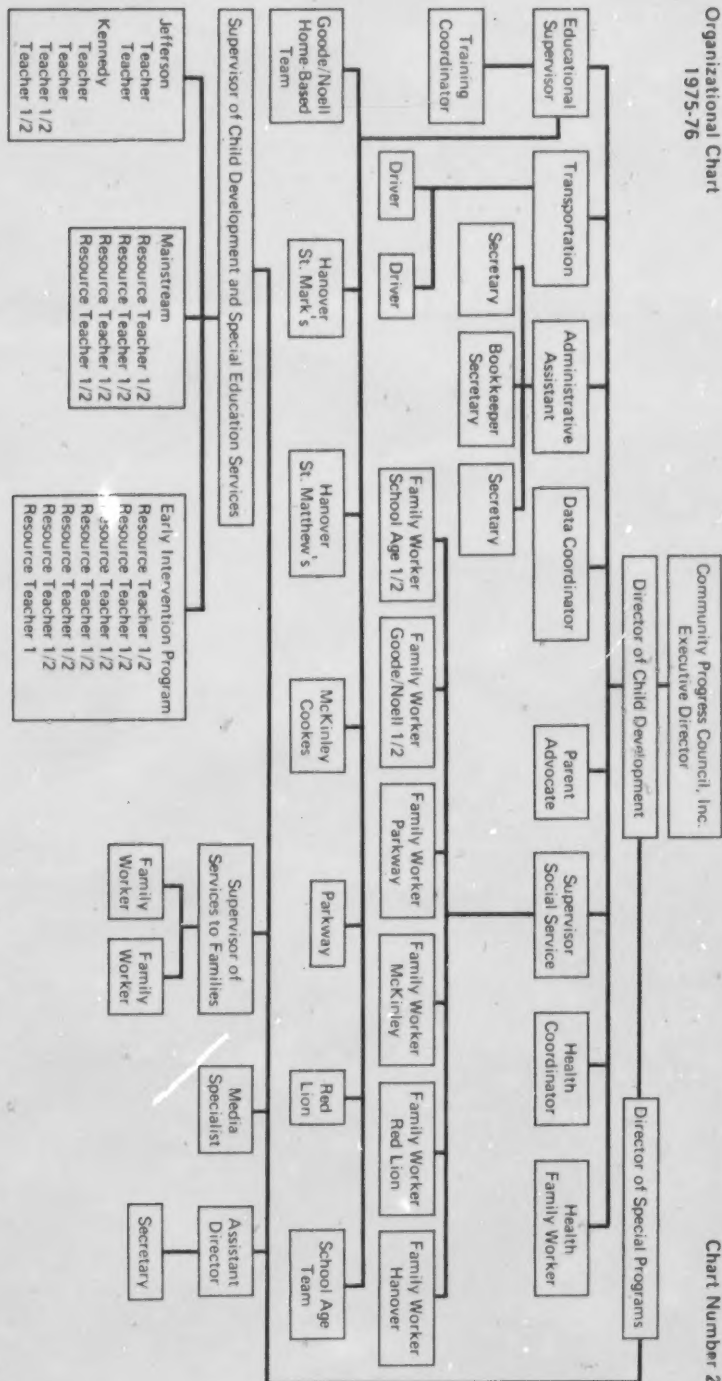
The First Chance Program receives federal funds from the Bureau of Education for the Handicapped, federal funds through ESEA, P.L. 89-313, and State/local funds through the York-Adams Mental Health/Mental Retardation Board.

The Child Development Centers are funded by H.E.W. Office of Child Development (Head Start) and Title XX Day Care (with local share provided by Pennsylvania Department of Community Affairs and Department of Public Welfare). The total funding for the combined program is \$650,000.

This combination of federal, state and local funds permitted us to develop a network of programs which serve children with handicaps. This network, made up of various service delivery settings, is served by one staff. Staff members are not locked into working with one aspect of the program. A Resource Teacher who works in a Mainstream Center in the morning will visit homes of infants and toddlers in the afternoon. In this way, the Resource Teacher understands the young child and his family as well as the preschooler. This system allows us to use all the talents of our staff members and gives the staff a fuller appreciation of programming for children from birth through elementary school. Further examples of this staffing pattern are illustrated in Chart 2.

Organizational Chart
1975-76

Chart Number 2



The staffing pattern of the First Chance Program demands that employees be as concerned about and able to work with families as they are concerned about and able to work with individual or groups of children. Since few child development or early education programs in colleges stress both or give practical experience in both, the staff has learned as they worked. Teaching staff and family workers meet weekly in individual or small group sessions with their supervisors. The consistent supervision of staff is an essential part of First Chance Program.

Four basic ideas guide the First Chance Program. **First**, the early identification of and intervention with families having children with special needs will be helpful to the child and to his/her family. **Second**, in order to establish goals to promote growth of the child and the total family both the needs of the family as well as the child should be assessed. **Third**, the staff should act as an advocate for the protection of the family's rights and responsibilities in planning for their own and their child's future. **Fourth**, the staff also acts as an advocate of the child's right to grow and live in the "normal" community. Services are designed to enhance growth in the total family's development, thus changing the focus from child-centered programming to family-centered programming.

Services to Families

Referrals are stimulated from parents, public schools, doctors, clinics, community social service agencies and ministers through an ongoing public education campaign. Brochures and posters are distributed at appropriate sites; public service radio announcements are broadcast; staff members make frequent contacts with representatives of agencies and a portable display unit has been constructed to provide program information at local fairs and exhibitions.

Referrals to a center program go to the Department of Services to Families and are assigned to a Family Worker, while referrals appropriate for the Early Intervention Program are assigned to Resource Teachers through the Department of Special Services.

In efforts to prepare families for referral to the program, the project requests that the referring agent have both parents sign the referral form indicating their awareness of an

agreement to the referral. The referring agent is asked to arrange for and to accompany the project staff person on the first visit to the home. This sharing of responsibility demonstrates the dual concern and interest of both parties while facilitating the entry of a new person into the home.

The helping process with the family begins with the initial visit. In meeting with the family, the staff member obtains pertinent data regarding the child and family, explains the program and services available, assesses the family's perception of problem areas, and schedules a date for intake evaluation. In the Early Intervention Program, the family is prepared for an evaluation to be done in the home. If the child clearly is not appropriate, e.g., over age six, resident of another county, etc., the family is referred to other sources. If the family is functioning under severe stress, immediate referrals may be made to other agencies to obtain support services.

The intake appointment may be scheduled at the project site or in the home. Evaluation of the child's level of functioning is reviewed by the staff representative and the family during this meeting. For potential center placements, the parents and staff representative complete a developmental assessment on the child and jointly review their responses. In the Early Intervention Program, the **Denver Developmental Screening Test¹** is used. If there are indications for the need to do further evaluations by medical, neurological, psychological or psychiatric consultants, the parents are advised and referred for this. Each family member is asked about how he/she sees the problems in the home. The staff gains an understanding of how the identified problems of the child effect the total family. Sometimes the child's special needs are only part of the cause for stress in the home. This information assists the staff, helping the family focus on and resolve other problems within the family. After this initial discussion, those concerns appropriately related to the child are cited as classroom and home objectives. If the child's level of develop-

¹W.K. Frankenburg and J.B. Dodds. *Denver Developmental Screening Test*. Denver: University of Colorado Medical Center, 1970.

ment precludes the ability to master the skill, a discussion is held with the family to help them develop realistic expectations. For example, parents may express concern over a child's inability to toilet himself. If the concern is appropriate for the child's functioning level, specific objectives may be developed for implementation in the classroom and the home. Staff schedules permit considerable flexibility so that teachers and social service staff can meet with fathers and siblings as well as with mothers. All family members are encouraged to work with the child on specific behavior objectives developed in cooperation with the teacher.

The Family Worker acts as a liaison between the family and the school. She/he visits the home regularly and participates in family-teacher conferences. The Family Worker would also be available to be with parents when they come to the center to observe, as well as to help the family with other concerns not directly related to the school but which affect family functioning. In the Early Intervention Program, the Resource Teacher fulfills a similar role as the Family Worker as well as that of teacher. Thus, each family has one primary contact person; this decreases the chances of a family getting mixed messages. If an Early Intervention Program family needs more assistance or requests Family Communication sessions, they are referred to Family Workers.

In the center-based program, families are provided with opportunities to observe the activities of the child's classroom through one-way mirrors. A staff member interprets teacher-child interaction and provides instructions on intervention techniques. We are beginning to have parents come into the classroom or into an individual session with the child and the teacher. In these sessions, the parent is taught to do an activity with the child. The teacher can observe the parent's approach to the child and the parent can try out new techniques with a helping hand close by. Families are encouraged to participate in the child's daily program both in the home and in the center. Family members are encouraged to share their observations and opinions and to offer suggestions at any time. When they have found a method that works with their child's particular problem, it can be carried into the classroom. The center Family Worker shares information with the family about the child's progress.

A team of social service staff members have received specialized training through the Philadelphia Child Guidance Clinic and are implementing a communications-based family counseling model for families within the total network. During Family Communications, the family and counselor are videotaped, and tapes are reviewed in peer supervision sessions. An additional ten training sessions by two family therapists is presently underway.

Parents of children in center-based programs also participate in self-selected training sessions during monthly parent meetings. Training topics have ranged from welfare rights to characteristics of the hyperactive child to child management. Speakers from community service agencies frequently act as presenters. The parent meetings also provide a support system for families and social outlets. Families have also used the parent meetings in developing fund-raising projects in order to provide baby-sitting services for their sessions, refreshments and to purchase special treats and equipment for the centers.

Because the project is dedicated to maximizing normalcy in all areas of development, parents of children served in all settings are urged to participate in activities, training, program planning and implementation, and evaluation sponsored jointly by the local Head Start System and the First Chance Program. Thus, families as well as children are mainstreamed and a large segment of the community can be exposed to the theories of normalization and deinstitutionalization of the handicapped.

Services to Children

First Chance/Child Development Centers operate seven center programs and two home-based programs. The School Age Center provides day care for children 6 to 10 years of age before and after school and for children 4 and 5 years old who are kindergarten or pre-kindergarten. The five regular (serving "Normal" children) Child Development Centers provides day care service five days per week from 6:30 a.m. to 5:30 p.m. Although all Child Development Centers serve children with special needs, Resource Teachers are in four centers, four mornings per week to work with 5 children who need extra help functioning in the mainstream. These

centers, which serve from 18 to 35 children plus the children with special needs, are designated as Mainstream Centers. There is also a home-based center experience program for children 3-5 years which service children of non-working parents. Two therapeutic classrooms for children 3-5 and a home-based program for children from birth to age 3 or 5 are discussed below. These two centers operate four days per week with two sessions daily.

The **Early Intervention Program (E.I.P.)** is a home-based program for families with children birth to age 3 or 6. York County is divided into seven areas, six served on a half-time basis and one served by a full time teacher. This program can potentially serve about 65 families with a total of 88 children. In three areas of the county where no Child Development Centers are established, the Resource Teacher serves children up to age 6.

The families are visited on a regular basis at a time when the total family can be involved (including fathers). The child is evaluated using the **Denver Developmental Screening Test**² unless other more detailed information is available. The information combined with the concerns of the family are considered in designing a program for the child. The **Infant Stimulation Curriculum**³, developed at the Ohio State University, is used. This curriculum is divided into six areas of development: cognition, locomotion, social/emotional, fine motor, receptive language, and expressive language.

The families visited have a variety and range of problems and concerns. In some cases, children are profoundly retarded and the families need emotional support as well as management techniques to help their child develop. In other homes, the child may be developing well, but the parents want help in adapting to parenthood, or this child, due to family problems, may be at risk for developmental delay, e.g., child abuse, failure to thrive, parental deprivation, or problems with older siblings. E.I.P. staff can serve families with a range of problems.

²Ibid.

³Bardwell, Sims, et al. **Infant Stimulation Curriculum**
Columbus: The Ohio State University, 1974.

There are a variety of ways a family may participate. Some families only want support on a monthly basis while the teacher may be available for home visits as frequently as twice a week. Whatever the schedule, the consistency of visits is important.

Progress of the children in the Early Intervention Program is determined in several ways: (1) Developmental lag remains the same, i.e., the child does not catch up, but the lag gets no worse; (2) the lag continues, but the degree is reduced, i.e., a 40% lag is reduced to 10% lag; (3) the developmental delay is eliminated and the child functions age appropriately; (4) the child maintains his/her non-delayed development and does not regress.

Developmental Centers

First Chance operates two centers with a therapeutic emphasis. The two centers see children who need a small group setting and individual planning. The children in these two centers are not yet able to function in a large group or require more individual work than is possible in another center.

The **Jefferson Developmental Center** is for children ages 3-5 who have emotional, social and/or behavioral problems. The children may also have secondary problems such as mental retardation, language delays, and mild cerebral palsy. A team teaching approach is used in the center with a male and female teacher (we have about 90% boys in the class). The teacher-child ratio is 1:3. The teachers work with the children around understanding themselves as individuals and on integration into small group activities. The teachers, with the family workers, explain the education program to the families who are invited to observe and to come into the classroom to learn how to use the techniques used in the classroom in the home.

The **Kennedy Developmental Program** serves children ages 3-5 who have mental retardation or cognitive problems. The children may also have other handicapping conditions in addition to the presenting problem. There are 10 children and 3 teachers in each session. These children receive individual programming as well as experience in group activities.

The teacher visits the children's homes at least monthly and plan to have families come into the center for some visits. This presents, to total families, the opportunity to see their child's school and to better understand how he/she spends the day at school. Families in which there is stress or problems are referred to the Services to Families Department for Family Communications sessions or other help.

In both the Jefferson and Kennedy Centers, sessions operate on a half-day basis, four days per week with a morning session and an afternoon session. The Jefferson and Kennedy Center children may accompany children from the Child Development Centers on field trips, special events, etc. This integrates children with special needs and regular children on short-term basis.

Mainstreaming Centers

Some children with special needs can function in a "normal" preschool. The child may need a little more attention by staff around particular problems. These children are mainstreamed in four Child Development Centers where First Chance has placed a special teacher to help the children integrate into a regular Child Development Center program where regular staff can meet his needs. The Resource Teachers are at the centers four mornings per week. Children may be mainstreamed for various amounts of time, e.g., four half-days, five full days, part mornings (2 hours rather than 4) or part-time (2 days per week or possibly for full day care). This permits us to mainstream children at the speed best for them and best for the center. When mainstreaming children, it is important for the child to be ready for the center and for the center to be ready for the child. The staff is presently assessing the "regular" children in the centers in order to determine the level of functioning in the class so that a child can be mainstreamed when the center can meet the needs of any child. This permits us to take into consideration the unique make-up of the children as well as the staff in a center. This also gives us time to prepare the Child Development Center staff for children who may be functioning lower than other children in the center. The center may need to change its program in order to meet a child's special needs. However, since all center programs are individualized, the inclusion of a

child with more intense problems can be accommodated.

A goal of mainstreaming is to support the staff so they can integrate handicapped children. The special teacher is a model and teacher, but also may free the regular staff so they can experience working with special children. The Resource Teacher helps in such a way that the mainstreaming is smooth for the child and for the center.

In the Jefferson, Kennedy and Mainstream Center, the **Rutland Center Developmental Scheme**⁴ is used. Four areas are: socialization, pre-academics, communications, and behavior. These are used as guidelines for planning and for evaluation.

The flow of the process of recruitment, evaluation, and finally entrance into a program is the foundation of a successful program. Unless these steps flow smoothly, child and family may become frustrated and quit, or staff may feel their effort futile if some part of this process breaks down.

Recruitment, as mentioned above, is an ongoing process. Face-to-face contacts with referral sources and parent-to-parent contacts have been the most successful means of recruitment. Evaluation of children for center programs, i.e., Jefferson, Kennedy, and Mainstream Centers, include input from the family, the center staff, evaluation by a psychologist, and input from other pertinent consultants, e.g., medical, physical therapy, speech and language, etc.

When a child is appropriate for center placement and his family agrees, the process of entering the family and child is begun. As with most systems, especially those funded such as ours, there is a great deal of paper work to be completed about each child. This is sometimes looked upon as a necessary evil, but the Family Workers attitude toward the forms can influence the approach parents take. Since the Family Worker usually sees both parents, the forms are explained to both and their individual questions and concerns are answered. This supports each parent being his/her own spokesperson.

⁴May M. Wood (Ed.). **The Rutland Center Model for Treating Emotionally Disturbed Children.** The Georgis Psychoeducational Network, 1972.

and decreases the pressure put on one parent to speak for the other. The parent's feeling about the information requested may indicate how the family deals with "personal" information and about their feeling about going to someone outside the family for help, e.g., "If my daughter were okay, I would not have to fill out these papers." Forms are a part of most programs; we try to use this time to gain more than a signature.

Preparation for a child to enter a new classroom is an involved process. It is a process which takes into account persons affected by the admission of a new student. The steps listed below follow the evaluation. Staffing is held on Monday with the Psychologist, Head of Special Service Department, Family Worker, Classroom Teachers, and Health Coordinator. Information from the intake and evaluation is presented and discussion on placement is made. If the child is to enter a Mainstream Center, the Head of Special Services Department notifies the Associate Director of Child Development Centers. The Resource Teacher notifies the center staff on Tuesday. If the child is placed in Jefferson or Kennedy, the staff is present at the staffing.

Two steps of the process for entrance follow simultaneously. The Family Worker notifies the family and arranges for them to visit, with their child, the assigned center on Thursday or Friday. At Kennedy and Jefferson, this visit is made during the noontime or after the P.M. class. The child has an opportunity to meet the teacher and become familiar with his new classroom without the demand also to adjust to other children. In the Mainstream Centers, the visit is held during a quiet time in the day.

During the week of the staffing and visit, the classroom teachers prepare the other children for a new classmate. The children may feel threatened by a new child and this preparation first lets them know they can trust the teacher to be honest with them about changes and this gives the child a chance to express his/her feelings about the change. This week also gives teachers a time to adjust to the upcoming change. It is just as important that they will have the time to prepare themselves for the change as it is for the child to have time to adjust.

On Wednesday or Thursday of the week after the visit to the Center, the child enters the program. It is felt that the first day of a week (we operate 4 days per week) is not the best day for a new child to start, and it is a day to remind the "old" children that a new child is coming.

Since separation from parents and adjustment to a new environment is a lot to ask a preschooler, we have a parent accompany the child at least the first week. If a parent is working, a grandparent, older sibling, etc. can come instead. It is important that this be a person the child trusts. The first day the parent stays in the classroom, the Family Worker talks with the parent before hand about his/her role during the first week. The parent helps the child get to know the teacher, children and room. The next step is to have the parent ask the teacher to join them in some project, for example, Parent: "I don't know where the trucks are, let's ask Jeriesha, your teacher." As the parent permits the teacher to do more, the child senses that the parent feels the teacher is okay. The parent may leave for short periods of time and then return. The parent may leave their coat or purse for the child as an indication that they will return. The purpose of this process is to help the child and parent feel comfortable about the classroom. It is a gradual process and one which may take several days. We feel it better to have a gradual non-traumatic entrance rather than have the child enter "cold-turkey" and be upset.

Depending on how long the above process takes, the mother or father may only spend a day in the classroom. The longest time needed thus far to achieve this transition was two weeks. Regardless of how quickly the child adjusts, the parent is still asked to come the first week. Time not spent in the classroom is spent in the observation room. When parents are required to come in at the beginning it seems to be easier for them to come back for regular visits. The longer visiting is put off, the more difficult it becomes. By the end of the week, parents know the teacher, other children, and perhaps other parents who have come to visit and other center staff.

The transition of a child from the Early Intervention Program into a center would follow the process described above.

If he was to enter a Mainstream Center, the process might be easier since the child's E.I.P. teacher and the Resource Teacher are the same person.

Since the system serves children birth through age ten, it is possible that a child could be in the program for several years. This provides an excellent means of following a child's progress and reduces the changes of a new program "starting over" with the child. There is continuity of services to the family and the child.

This system discourages the labeling of children. In several instances, children who had been labeled by others were mislabeled; therein, creating problems for the child and for those planning the programs. If a child is with this system, he/she is not labeled and development is encouraged which will permit the child to function in the mainstream of life.

Future Services

The growth of the First Chance Program from its beginning in 1973 until the end of 1975 has been great. The Program increased its capacity from 12 children to 140, better than 1,000% increase, and its staff from 8 to 20 or about 150% increase.

As First Chance and the Child Development Centers worked together it became apparent that combining programs into one system would be appropriate. Each program had many things to offer the other and the integration should be more efficient and improve service delivery. A minor thing such as the development of an application for use across the system has decreased the number of forms a family moving across program has to fill out. Again, a diagram of the proposed integrated system will help one understand this tentative plan.

Chart Number 3



This is a tentative plan; the final plan will not be fully operational until July, 1976, and depends on approval by the Community Progress Council Board and on the awarding of new or second year program grants to this agency.

The philosophy behind this revised plan might best be stated as "what is good for children and families in one part of the program is good for all children and families." This, of course, does not mean a "cookie cutter" program, but one that utilizes the workable parts and pulls them together.

The next six months will be spent finalizing this or a similar plan. Such things as the consistency of record keeping and data collection across the system will be promoted. The Child Development Centers have experience in some areas of programming and their expertise can save time and reduce the development of duplicate services, forms, etc. by First Chance staff. The Education Supervisor for Child Development and Special Education will work together to reduce duplication of service or work role and to increase service across the system, each acting as a consultant to the other. All Family Workers will be supervised by one person rather than have a supervisor for Child Development Centers and one in First Chance. This integration of two programs is not a task achieved easily or quickly. It will take time to determine the final plan.

Another aspect of future programming is the replication of specific components of this network of services by other preschool programs serving similar target populations. Child Development, York* has applied for a replication grant from the Bureau of Education for the Handicapped for the next funding year 1976-77. If funded, training and consultation will be available to appropriate preschool programs at little or no cost. Our experience during these last two and one half years of rapid growth and development should serve other projects well, especially those that also believe families should participate actively in all phases of the program.

*The First Chance Child Development Centers are in the process of changing their name to Child Development, York.

This article has described the development of a system which provides day care and therapeutic service to the children in York County. A program unique because it combined two existing child care programs into one system; because it combined local, state and federal projects into one system; because it provides a continuous child care system for children from birth to age ten; and because it provides service to children and their families. This is a system in process. We welcome inquiries from others interested in our system.

A major task facing every newly established Early Intervention Project is developing working relationships with local Agencies and individuals who are involved in identifying and serving young children. For projects designed to work with handicapped and high-risk children from early infancy, the referral and programming process. The article below describes how one project successfully achieved this cooperation.*

**Cooperation with the Medical Community:
The Key to Success of Early Intervention Programs**

by

Marilyn S. Perrin and Mariemma L. Sgro

The gap in services to children under three in Blair County was readily acknowledged by both social service agencies and the medical community. When we began to develop our concept of an Early Intervention Program, it seemed important to us to begin by establishing an integrated community network of all those agencies and individuals in contact with infants. Within this network, we defined our role in terms of coordinating existing services, teaching, and offering support to parents of developmentally delayed infants.

Our first step was to approach all the social service agencies and affiliates of the medical community to discuss this integrated approach. Personal visits were made to define our particular relationship with each individual agency. The relationship was assessed in terms of which staff members in that agency were involved with infants and to what extent.

*The project described is sponsored by the Blair County Chapter, Pennsylvania Association for Retarded Citizens. It serves handicapped and high-risk children birth through 2 years in a totally home-based model.

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The Early Intervention Program was then presented as a supportive service to work in conjunction with each agency. Examples of our cooperative effort with local social service agencies follow:

Head Start Program

The local Head Start Program already had an established emphasis on home visitation and parent education. Head Start caseworkers making home visitations could easily refer to us younger children in the same home who could benefit from our program. As a result, prescriptive teaching stimulation programs were discussed at monthly conferences between Head Start and the Early Intervention Program. Also, Head Start teachers aided in the implementation of stimulation programs designed for infants in the same home as a Head Start child, thus eliminating the necessity for home visits from two different agencies.

Easter Seal Society

Physical therapy is an important component of the Early Intervention Program. Since our program had no physical therapist on staff, therapy services were coordinated through the Easter Seal Society. Infants were scheduled at this agency for a physical therapy evaluation, with the Early Intervention Coordinator and parents present. The Coordinator then integrated this evaluation with the total program for the child and established ongoing communication with the therapist for continuous re-evaluation. In return, the Easter Seal Society referred to the Early Intervention Program for involvement in the overall program.

Catholic Child Care Center

This residential Center, which serves children being processed for foster and adoptive care, was approached in regard to referrals and coordination. The relationship was designed to provide referrals to the Early Intervention Program and prescriptive stimulation for those infants housed at the Center. Denver Developmental Screening Tests were completed on all children and prescriptive programs written for those infants demonstrating delay. The staff of the Center cooperated in implementing these programs, and once placement of the child

occurred, the new parents became a part of the Early Intervention Program.

During our discussions with various agencies and individual families, it became clear to us that our most important relationship would have to be with the medical community. Physicians, hospital personnel, and clinics were most often the first to become aware of an infant's problem. Their cooperation was essential for early referrals to our program. Without the stated support of the physician, many families were unwilling to accept the need for an Early Intervention Program for their child. And without an understanding of the Early Intervention Program, physicians would not encourage parents to follow through with the individual prescriptive programs.

Therefore, we established a definition of the medical community as:

- Physicians
- Nurses
- Hospital Social Service
- Home Nursing - Maternal Child Care Program
- State Health Clinics (Pre-natal, Well-baby, Orthopedic)
- Family Practice Program
- Student Nurses
- Residents and Interns

We began personal visits and presentations to all the above groups. We emphasized three major components in working toward cooperation with the medical community. First, demonstration to the medical community of what is meant by early intervention. Second, maintaining lines of communication with the community. Third, continuous follow-up with the medical community.

One of the first contacts made was with our county Home Nursing Agency - Maternal Child Care Division. Our program was described in detail and referrals were immediate. We made certain that each child's evaluation and prescriptive program were sent to the agency. In several cases, it became apparent that both the Early Intervention Program and the Home Nursing Agency would be involved. In order not to duplicate some of the services and not to "bombard" the home with workers unnecessarily, we discussed using a member of the Maternal Child Care staff to implement our pre-

scriptive program. The aide already having a rapport and entering the home on a regular basis could easily use part of her time with the infant and family in carrying out the program. To keep close contact for good follow through, meetings were set up between the two staffs for the first Friday morning of every month.

Thus, in addition to progress notes and close phone communication, we had a regularly scheduled conference to discuss any situation which could arise as a result of unclear messages, etc. The Early Intervention Program monitored each case in which an aide from Home Nursing was utilized; in addition, we systematically re-evaluated and up-dated individual programs. Thus, we were released from providing the continual visits. For each child, a caseworker was assigned from the Home Nursing Agency or from the Early Intervention Program, but never both. Duplicate referrals to supportive services were eliminated and mutual support was developed.

To extend our cooperation with the medical community a list of physicians currently serving those infants referred to our program was compiled. Every individual program written was mailed to the physician most involved with that particular child. Appointments to meet with each physician were set. The Early Intervention Director, Program Coordinator, and a mother met with each physician at a time and place of his convenience. A Description of the Early Intervention Program, as well as brochures and sample individual prescriptive programs, were presented. Good prescriptive programming, implementation, counseling, follow through, etc., must all be necessities before physicians are expected to listen. We felt as though components were well developed; therefore, it was time to avidly present them if we were to serve all infants possible.

The physician frequently indicated concern about the relationship between themselves and the Early Intervention Program. Many physicians wanted short, written progress reports which we were careful to send periodically. In return, we wanted feedback from the physician concerning suggestions and criticisms. We also asked the physician to help us implement the program with the family. Could we feel free

to call the physician for his advice on particular questions, such as the child's physical ability to perform a certain task? For example, if a particular child had a shunt, were we endangering him in any way by working with him in specific gross motor areas?

After building rapport with a few physicians, we gradually built up our own confidence to speak with assurance to members of the medical profession. We realized that initially all of our staff members had been a little in awe of dealing professionally with physicians. We overcame this feeling when we acknowledge honestly that we had a professional quality program which could be offered as an adjunct of medical service. Our individual prescriptive programs had been studied by various other professionals such as occupational therapists, physical therapists, physicians, as well as parents. One of the first physicians to refer an infant to us asked that he be permitted to randomly question any of those families he referred for feedback on our total program. We agreed to this and the feedback he received was positive. Thus, all the effort put into developing a good, rounded quality program was recognized by professionals as well as parents. As a result, our confidence increased and the physicians cooperated more willingly. We were invited by a major pediatrician from the area to present our Early Intervention Program to a group of pediatricians and residents at a local hospital. This resulted in receiving requests for evaluation directly from the hospital while infants and toddlers were patients. Nurses, interns, and residents became aware of the Early Intervention Program as a result of our presence in the hospital. We began having some student nurses accompany us on home visits while others made visits alone as part of their nurse's training. Although we did not utilize these students to actually implement the individual, prescriptive program, they became familiar with each child's needs and we used them as models for the parents in creative play and positive behavior control.

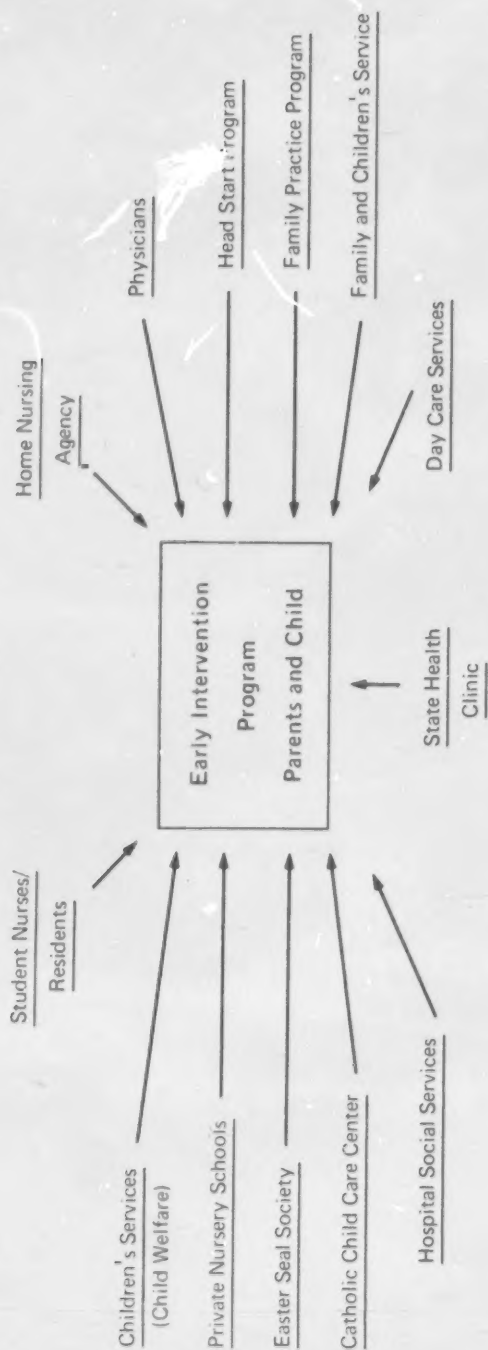
The presentation of Early Intervention to first and second year medical residents was another one of our means of reaching the medical community. We felt that exposure at the onset of their medical career would help tremendously in shaping their orientation as they move into communities as future physicians and have a far-reaching effect.

Another line with our medical community was the coordination and communication between the State Health Clinic and the Early Intervention Program. In writing a prescriptive program for an infant with a physical handicap, input from a physical therapist and/or orthopedist was necessary. An appointment was made by the Early Intervention Program with the Health Clinic to meet with their orthopedic surgeon who operates a monthly orthopedic clinic, open to anyone. Again we presented the Early Intervention Program. We asked if we could accompany the children we referred to the clinic and receive input from the doctor during the work-up for home implementation. The State Health Clinic and the orthopedic surgeon were receptive. The channels for communication will remain open here through the Early Intervention Program staff member who will be accompanying each child and parent.

Our program has now been functioning for a year. During this initial period, there is no doubt that our greatest impetus for growth, after developing a comprehensive quality program, came as a result of our successful cooperation with other agencies, but most particularly with the medical community. Early referrals increased significantly and physicians encouraged families to accept our intervention programs. A truly integrated system of services, without unnecessary duplication, now exists in our community for developmentally delayed infants. We will continue to work together.

Community Network

Emphasis on Medical Community



An important component of a comprehensive Early Intervention Project is Community Education. Activities designed toward this should be directed toward alerting the community about the importance of Early Identification of children with developmental lags, informing about the availability of programs to assist such children and their families, providing orientation to the objectives, activities, and techniques utilized in Early Intervention Programs, and soliciting support for establishing and maintaining such programs. The article below describes an innovative approach to assist staff in providing Community Education services, utilizing a portable display model house, and video-tape techniques.

**An Innovative Approach for
Community Education About Early Intervention**

by

**Lynd Fiorentino
Patricia Whalen
Elaine Freeman**

The Early Intervention Program sponsored by the Chester County Association for Retarded Citizens has three basic components: a home-based program for infants from birth to two years, three centers for children from two years to school age, and a resource consulting service for six generic day care centers.

Up until this year, the programs have been known as "Infant Stimulation," the "Tom Thumb Schools and Developmental Center," and the Field Program. Chester County Association for Retarded Citizens has now moved to unite the

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projects into **FIRST STEP OF CHESTER COUNTY**. This new arrangement should permit greater flexibility in future programming for individual children. Administratively, it should also provide greater efficiency and economy as a concerted program. We hope to alert the community more effectively to the range of preschool services available through the efforts of the combined staffs and parent groups. Two public information projects will be discussed later in this article.

The staff for these projects includes Special Education Teachers and Aides, a Speech Clinician, Registered Nurses, a bi-lingual Teacher for Spanish-speaking children, a Social Worker, Physical Therapist, Occupational Therapist, and Music Therapist. The centers, which receive State and Federal funding, are located in areas selected to facilitate easy and natural integration of our children with children in Head Start programs.

Over the past three years, the Early Intervention Program in Chester County has expanded its methodology and program documentation. Our experience has increased our conviction in the validity of this undertaking. However, the staff is continually faced with three problems: first, identification in the general population of those children in need of our services; secondly, the general public's lack of knowledge of early intervention; and thirdly, the medical community's need for greater familiarity with our program.

What is infant stimulation? What do you teach babies? Why is an early intervention program necessary? These are familiar questions to staff members of any early intervention program.

Challenged by the need to answer these questions and a desire to provide a support mechanism to the available written materials, our staff designed a display package to focus on the concept of sequential development. In order to effectively utilize this display, we agreed that it must be light-weight and portable, inexpensive to construct, and appealing in content to both the professional community and the general public.

Our idea evolved into a model house, 18"x24"x8", constructed of plywood. Footstep cutouts on the interior walls illustrate the developmental steps of an infant from

birth to two years of age. The house is furnished with objects in the home environment which are important to each of these early stages of development. For example, a mobile over the crib, steps for climbing, a rocking chair, simple books, and outdoor play equipment. The doll family simulates activities which are both pleasurable and essential to a child's development.



In the foreground of the model house, four of the most frequently used activities in the program are briefly explained. Toweling, the cylinder, the beach ball, and the incline board are shown.

A light-weight, free-standing poster, prepared by our speech therapist, traces language and speech development. Rounding out the display is a mobile and a collection of objects to demonstrate how inexpensive household items can provide tactile and sensory stimulation for an infant.



This display meets all the staff's requirements. It is easy to transport and to assemble and was inexpensive to construct. We feel that it is an attractive and eye-catching means of telling the community who we are and what we do. The model house should also be helpful in initial visits with parents of delayed infants. It explains much about our program and goals in a supportive manner.

Our complete display has been featured at a Regional in-service meeting for staff of Community Early Intervention Projects, a community health fair, in a community room of the Chester County Public Library, the Chester County Courthouse Annex, and a local shopping mall.

In considering additional means to acquaint the professional community of Chester County with our early intervention work, we decided a visual presentation of an actual

home visit would be helpful. During the past three years, we had occasionally tried showing slides of children in the program, but felt the slides had not adequately shown the activity program.

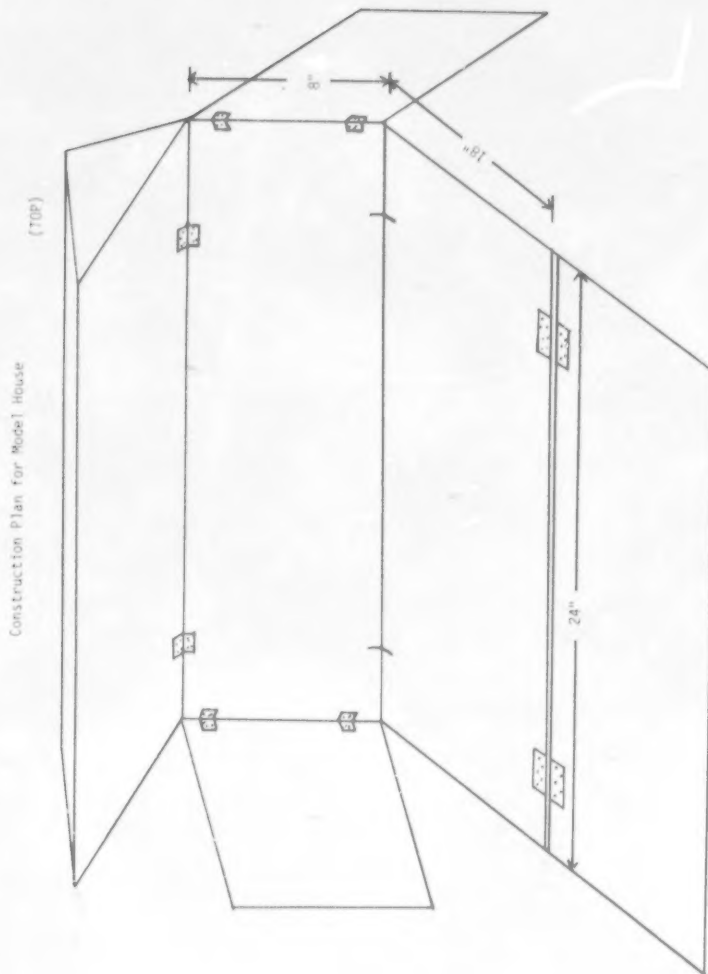
Not having the budget for a professional film, we turned to an alternative - producing a video tape. Following a preliminary planning session, outlining and blocking out the sequence of activities, the equipment was taken to the home of a child in the program.

The subject we selected for the presentation was an eight-month-old girl with Down's syndrome. Her mother, a former professional dancer, was very willing to participate in the program. Her ease and fluid movements in handling her child made them an ideal choice for demonstration purposes. The family had been participating in the program since the child was eight weeks old.

The usual hour visit was abbreviated for the presentation. The session begins with the mother preparing the baby for exercises. Toweling, head lifting, eye focus, turn to sit are among the activities demonstrated. The mother models the activities and the teacher/therapist makes some comments. Next, the teacher demonstrates some new exercises and the mother models them back.

The tape we produced will serve the original purpose. We hope to show this presentation to all the hospital staffs in the county. We would like all nurses, doctors (especially obstetricians and pediatricians), and technicians to be aware of how we proceed with infants.

The first showing of this tape will be to student nurses at Coatsville Hospital. We plan to use it with special education students at West Chester State College and Pennsylvania State University as well as other interested community groups.



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Current Readings in Early Intervention**

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